Aging and Long Term Care

(10 Hours/units)

*Course Objectives***:**

1. Describe at least two important aspects of aging and long-term care.
2. Explain at least one psychological aspect of aging.
3. Explain at least one biological aspect of aging.
4. Explain at least one social aspect of aging.
5. Describe at least one key factor in the relationship between aging, culture and stigma.
6. Discuss at least one key difference between long term and alternative types of care.
7. Identify at least two elder and dependent abuse warning signs.
8. Discuss at least two principles and techniques used in counseling the elderly.
9. Identify at least two relevant issues and clinical implications in coping with aging.
10. Describe at least two clinical implications and issues surrounding the elderly and substance abuse.
11. Identify at least two relevant resources.

In addition to the course objectives listed, this course addresses the following content areas related to aging and long term care:
   ✓ Counseling theory and practice
   ✓ Social and Cultural Foundations
   ✓ Assessment
   ✓ Professional practice issues
   ✓ Wellness and prevention
   ✓ Human growth and development

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1. Aging, Demographic Information, Stigma, and Culture

Nearly one in five older adults have one or more mental health or substance use conditions (referred to in this document under the umbrella term, "behavioral health"). About 16 percent of women and 11 percent of men age 65 and older experience symptoms of depression.iii The majority of older adults' behavioral health issues are identified and treated in primary care settings instead of specialty behavioral health settings. Older adults are distinct from other populations in key ways:

➡ **Complex chronic health conditions**. Older adults are

✓ **THE NUMBER OF AMERICANS AGE 65 AND OLDER INCREASED BY 25 PERCENT FROM 2003 TO 2013 AND THE NEXT 25 YEARS PROMISE ANOTHER 50 PERCENT INCREASE. FROM 2018 TO 2038, THE NUMBER OF AMERICANS AGE 85 AND OLDER IS EXPECTED TO MORE THAN DOUBLE FROM 6 MILLION TO 14.6**

more likely than any other age group to have complex chronic health conditions, including mental health conditions, substance use disorders and cognitive impairments. About two-thirds of older adults have two or more chronic conditions.

➡ **Drug use and abuse.** Older adults receive a high proportion of prescription drugs in the U.S. due to increased likelihood of being prescribed long-term and multiple medications.vi Improper use is common, whether because of cognitive decline or attempting to save money by using their medications sparingly or taking another person's remaining medications. Additionally, commonly prescribed medications – opioids for pain and benzodiazepines used to treat anxiety and sleep disorders – are addictive and can increase the risk of falls and memory/ retention issues affecting up to 17 percent of older adults.vii Co-morbid health conditions, age-related changes in drug metabolism; potential interactions with prescribed drugs, over-the-counter medications, dietary supplements and alcohol; and cognitive decline make drug misuse a special concern.

➡ **Health disparities.** Life expectancy and overall health have improved for most Americans in recent years, but factors related to economic status, race, sexual orientation, gender identity and rural status, as well as limited access to adequate housing and transportation services, keep many older adults from benefiting from these gains.

➡ **Safety concerns.** Individuals become more frail as they age and their risk of falls and injury increases. One in every three adults aged 65 or older falls each year and falls are the leading cause of both fatal and nonfatal injuries for older adults.ix

➡ **Loss is common.** Some older adults may experience loss. Loss of spouses, friends, physical functioning, independence, routine and sense of purpose affects overall health, including mental health and substance use. Health care providers and older adults often mistake depression for a natural response to aging. This can lead providers to not screen for or treat depression and older adults to not seek help.

➡ **Elder abuse.** Elder abuse is a serious problem, with an estimated 8 to 10 percent of older adults experiencing abuse, not including financial exploitation.x Other estimates found that between one and two million older adults are mistreated each year, while only 27 percent of hospital emergency departments have elder abuse protocols (compared with 75 percent for child abuse).

➡ **Negative attitudes and discrimination toward people with behavioral health concerns.** These attitudes can be a barrier for all age

groups. Generational and cultural differences may be a barrier to identifying concerns, treatment follow-through and active engagement in behavioral health treatment.

SALLY IS 83 and recently fractured a hip. She has severe osteoporosis, high blood pressure, chronic pain and a history of depression. She is cared for by her daughter who is trying to get her to move into an assisted living center, but Sally refuses, saying she can live on her own. Using a standardized screening tool, Sally's integrated primary and behavioral health care program identified increasing depressive symptoms. An assessment for pain management prompted a full review of medications for effectiveness and risk of abuse, leading to changes in her prescriptions to decrease side effects and increase function. An in-house social worker provided support and intervention for Sally and her daughter regarding care decisions and ultimately connected them with an external caregiver sup-port provider. Together, they identified the resources Sally needed in her home to manage her health.

While providers, family members, peers and community stakeholders must be aware of these concerns, it is also important to be skeptical of antiquated stereotypes and assumptions about older adults' health status. Older adults remain physically active for longer than ever before, continue to be active learners and frequently use health technologies to manage their health. Most older adults do not have a cognitive impairment. Recovery from depression, back pain and other injuries or illnesses is the norm. The overall category of older adults (age 65 and older) is further divided into subgroups – "young old" (65-74 years), "middle old" (75-84 years) and "oldest old" (85+ years) – to help understand variability in

CAREGIVER CONCERNS: UNDERSTANDING THE ROLE OF THE FAMILY

As some adults age, they may begin to rely more heavily on spouses, children, grandchildren and other loved ones for assistance with daily living activities and navigating the health care system. Unlike the pediatric population, where parents legally and functionally act as caregiver and deci-sion-maker for their child, caregiver relationships for older adults are much less straightforward and obvious. In conditions like dementia, capacities are slowly lost and there is often not a clear point at which patients require surrogate decision-makers.

Family caregivers, as well as paid home health workers, often advocate for their loved one in addition to providing needed care to compensate for workforce shortages and gaps in service. Primary care providers integrating behavioral health must support patient empowerment, encouraging as much patient control over treatment and life decisions as possible, while also building caregivers into decision-making to improve outcomes. Providers must not only care for the patient, but also the caregiver; one-third of caregivers report their health as being fair to poor. Caregivers need resources on mental health and substance use disorders, including support on how to handle their stress and obtain treatment for behavioral health concerns and other chronic conditions. The best models for promoting the caregiver relationship and supporting caregivers are those that are easy to access and culturally informed.

patient's experiences. However, it is important to consider an individual's functional age as well as their chronological age. Patient-centered care requires that you treat all of your patients, regardless of age, as individuals with unique strengths, histories and needs. Successful practices establish outcome measures that meet the range of behavioral health and primary care needs of older populations.

Behavioral Health and Physical Health
In older adults, physical, behavioral and cognitive conditions often present differently than younger adults. To assist in understanding these differences, keep in mind that:

➡ **Physical health conditions** often present as behavioral health concerns or cognitive impairments.
➡ **Behavioral health conditions** often present as physical conditions or cognitive impairments.
➡ **Many medications have side effects** that may present as symptoms of another illness. The interaction of multiple medications can exacerbate symptoms and even cause health problems. Further, sometimes having a condition, such as dementia, prevents older adults from being able to take medications for other conditions due to potential interactions.
➡ **Depression often occurs with physical health conditions.** Symptoms of dementia and delirium frequently emerge in conjunction with many behavioral health and physical health conditions.

Ensuring an Integrated Behavioral Health and Primary Care Workforce for an Aging Population
Given the unique and complex needs of older adults, what can be done to ensure that the safety-net primary care workforce is prepared to meet the behavioral health needs of this aging population? Since it is unlikely that there will ever be enough specialty behavioral health providers, primary care organizations are now focusing on adapting their systems and expanding their existing workforce skill sets to include behavioral health. The coordination of primary and behavioral health services is also called integrated care. The SAMHSA-HRSA Center for Integrated Health Solutions describe the Core Competencies for Integrated Behavioral Health and Primary Care. The following lists specific strategies for serving older adults as they relate to each of the core competencies:

1. Interpersonal Communication

Provide anticipatory guidance for patients and caregivers, especially related to advanced care planning. Actively engage family members who may not accompany patients to appointments but are part of the patient's care. Accommodate for the impact of dementia, language and hearing barriers. Avoid confusing medical terminology. Clearly ex-plain medication and treatment options, repeat when necessary and provide in writing using

friendly, helpful, accessible language. Tap into the patient's strengths to promote self-management and communicate positive views of aging. Recognize sensory changes that occur with age such as diminished peripheral vision and differential auditory strength.

2. Collaboration and Teamwork

Recognize that one provider provider cannot address all medical and behavioral health needs in 15-20 minutes. Use an informed team approach to provide comprehensive services, with all team members aware of their responsibilities. Train non-medical staff to conduct environmental, social and medical histories and screenings. Establish working relationships with other internal and external members of the care team. Listen to patient and caregiver and recognize that the desired outcome for older adults may be a change in function, not a change in symptoms. Refer to specialty behavioral health care or aging services as needed or use telebehavioral health, especially in rural settings.

3. Screening and Assessment.

Screen for depression, anxiety, substance use, chronic pain, risk of falls — including any recent stressful events that can elevate risk of a fall— and abuse. Identify general health concerns that affect or manifest as behavioral health symptoms. Be cognizant of gender differences in prevalence of behavioral health conditions— women are more likely to experience depression, dementia and trauma, while men are more likely to abuse alcohol and prescription drugs. It is especially important that providers differentiate between depression, delirium and dementia. Implement a protocol for suspected abuse and ensure that all members of the care team, including front desk staff, know the warning signs of elder abuse. Be aware of the risk of pain medication abuse/opioid dependency. Monitor for suicide risk. Have a consultation arrangement in

CONSIDER USING NON-CLINICAL LANGUAGE to discuss behavioral health systems (e.g., "stressed" instead of "anxious," "sad" instead of "depressed").

place with geriatric mental health and substance use disorder specialists that includes conducting a medication review.

4. Care Planning and Care Coordination. Engage unpaid and paid caregivers in care planning. Identify and use aging system resources like peer support and advanced care planning supports (see "Resources" for additional ideas). Collaborate with the pharmacist to ensure proper prescribing and dosage to avoid medication risks. Older adults may need additional help accessing follow-up care. Employ warm hand-offs to ensure continuity of care. Recognize the appropriate-ness of short, time-limited interventions for addressing many mental health and substance use concerns (e.g., Florida BRITE).

5. Intervention. Understand common ailments of older adults that should trigger a primary care evaluation. Physical symptoms are often caused by stress, trauma, loss and mental health conditions while physical health conditions may manifest as behavioral concerns. Implement evidence-based practices that are known to be effective for older adults and refer to specialist behavioral health providers who use best practices in your community (see "Resources" for suggestions). Avoid inappropriately prescribing antipsychotics to alter behavior in older adults with cognitive impairments.

6. Cultural Competence and Adaptation. Check if your physical space is accessible for older adults (e.g., wider doorways, exam rooms with space for caregivers, handrails, smooth transitions at doorways). Recognize and respect cultural differences with patient and caregiver involvement. Understand the role negative attitudes and discrimination can play for various cultural groups and older adults. Accommodate generational differences in use of technology and cultural acceptance of questioning or not questioning providers. Use formal and informal community resources to overcome geographic and transportation barriers in rural areas.

7. Systems-Oriented Practice. Understand and explain Medicare benefits, including Part D and preventive benefits (e.g., alcohol misuse screening, depression screening) to patients and their caregivers. Coordinate benefits for dually eligible Medicaid/Medicare beneficiaries, including certain social services that are available with lower cost sharing. As the health care landscape changes (for instance, accountable care organizations [ACOs] are

established), ensure that a staff member is equipped to help patients understand and use their benefits.

8. Practice-Based Learning and Quality Improvement. Measure patient and family caregiver satisfaction. Provide continual staff training related to major competencies and best practices for older adults. Learn to recognize behavioral disorders. Monitor avoidable negative health outcomes that are more prevalent with older adults and implement quality improvement protocols (e.g., injuries, infections, adverse reactions to multiple medications).

9. Informatics. Establish electronic health records that include multiple providers, all prescriptions, social service notes and clinical decision support tools. Use large print informational materials. Ensure kiosks and other touchpad technologies have large buttons. Address privacy concerns related to sharing health information.

Evidence-based guidelines are a great resource for identifying clinical, organizational and systems level changes to improve care for older adults. The National Coalition on Mental Health and Aging has compiled a directory of competencies, standards and guidelines for providers working with older adults encountering behavioral health concerns. Many other national provider organizations have practice guidelines and protocols to consider when working with older adults (See the resource chapter at the end of this course).

The Role of the Community
Primary care providers are not alone in caring for the aging population. Caregivers, neighbors, friends and community-based organizations also play a vital part in supporting older adults' prima-ry and behavioral health. Rural communities with workforce shortages are of special concern and older adults may have to depend on community partnerships and existing informal networks of friends and neighbors to promote healthy behaviors and allow them to remain in their own homes and engaged in community life. As part of care coordination, providers must know the community resources equipped to address social determinants of health, elder abuse and isolation, and appropriately connect patients to those services.

Your community may have the following organizations and services

> ✓ Adult protective services
> ✓ Nutrition programs
> ✓ Senior centers
> ✓ Transportation services

available to serve as partners in the health promotion and disease prevention of older adults:

The Eldercare Locater can help you find these resources in your community. In addition, Mental Health First Aid for Older Adults provides community members with the required tools to identify a behavioral health problem and get their neighbor, friend or loved one help. A more informed community can be integral to addressing gaps in services and promoting the health of all its citizens, especially older adults with potential mental health and substance use concerns.

Older Adults Resources: Behavioral Health Identification and Treatment

The Treatment of Depression in Older Adults : Evidence-Based Practices KITs — A SAMHSA publication that provides an array of evidence-based programs to treat depression and dysthymia

Substance Abuse by "Mature" Adults: Is Your Patient Using or Abusing? — A video with Louis A. Trevisan, MD that describes how to identify and address substance abuse in older adults

Preventing Suicide in Older Adults — An issue brief from SAMHSA and the Administration on Aging to help health care and social service organizations develop strategies to prevent suicide in older adults

Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities — A SAMHSA publication that includes guidelines for integrating suicide prevention into ongoing programs, hands-on tools, and training manuals for senior living communities

Evidence-Based integrated Care Practices for Older Adults Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) —

Collaborative care approach to treat depression or dysthymia that involves a trained depression care manager, patient, primary care provider and psychiatrist.

Wellness Initiative for Senior Education (WISE) — Health promotion program related to health behaviors, the aging process, managing care, medication management and signs of alcohol misuse and depression.

EnhanceWellness — Helps older adults with chronic health conditions manage their illness and avoid psychiatric medications, physical inactivity, depression and social isolation.

Senior Reach — Training for community partners to identify older adults experiencing mental health and related concerns and help get them into recovery-oriented behavioral health treatment.

Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) – A program that integrates depression awareness and management into existing case management services.

Program to Encourage Active, Rewarding Lives (PEARLS) — Community-based intervention for individuals with depression or dysthymia that helps reduce symptoms and suicidal ideation through problem-solving, social and physical activation and pleasant activity scheduling.

Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT) — Primary care intervention to recognize depression and suicidal risk and manage treatment.

SAM'S SON brought him to see his primary care provider saying that Sam was increasingly confused over the past week. His wife died last month and now Sam lives alone, but his children check in on him daily. Sam's primary care provider evaluated him for physical causes of confusion (e.g., dehydration, urinary tract infection, stroke) and for depression. His primary care provider also asked Sam's son about his own level of stress. As a result, the provider connected Sam with their in-house counselor to provide grief counseling for Sam and identified outside resources to support Sam's son as a caregiver.

Resources for Enhancing Alzheimer's Caregiver Health II (REACH II)
— At home and telephone-based intervention to reduce caregiver burden and depression, improve self-care and offer
social support.

Brief Screens for Providers

- ❖ Depression Screen — Patient Health Questionnaire (PHQ-9)
- ❖ Anxiety Screen — Generalized Anxiety Disorder 7-item scale (GAD-7)
- ❖ Cognitive Measure for Dementia — The Mini-Cog
- ❖ Cognitive Impairment Screen — Montreal Cognitive Assessment (MoCA)
- ❖ Dementia Functional Assessment — Functional Activities Questionnaire (FAQ)
- ❖ Delirium Assessment Tool — The Confusion Assessment Methods
- ❖ Diagnostic Algorithm (The CAM) Brief Alcohol Screen — Alcohol Use Disorders Identification Test (AUDIT-C)
- ❖ Opioid Abuse/Chronic Pain Medication Abuse Screen — The Opioid Risk Tool (ORT)

Integrated Care Workforce Resources

Association for Gerontology in Higher Education — Online Directory of Educational Programs in Gerontology and Geriatrics

National Institute on Aging - Talking with Your Older Patient

SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) — Workforce Resources

Organizations Related to Care for Older Populations

AARP — www.aarp.org/health
Administration for Community Living — www.acl.gov
Elder Abuse Resources — www.aoa.acl.gov

The American Geriatrics Society — www.americangeriatrics.org
American Association for Geriatric Psychiatry — www.aagponline.org
Caregiver Action Network — www.caregiveraction.org
Center for Medicare and Medicaid Services — www.CMS.gov

Family Caregiver Alliance-National Center on Caregiving — https://caregiver.org/national-center-caregiving
National Alliance for Caregiving — www.caregiving.org
National Clearinghouse on Abuse in Later Life — www.ncall.us
National Council on Aging — www.ncoa.org
National Institute on Aging — www.nia.nih.gov
Veterans Administration — www.va.gov/geriatrics

Aging is defined as "the accumulation of changes in an organism over time." Aging is also a multidimensional process of physical, psychological, and social change *(Masoro E.J. & Austad S.N. eds: Handbook of the Biology of Aging, Sixth Edition. Academic Press. San Diego, CA, USA)*. Some dimensions of aging grow and expand over time, while others decline. For example, although reaction time may decrease with age, knowledge of world events and wisdom may increase. Research shows that even late in life potential exists for physical, mental, and social growth and development *(Strawbridge, W.J., Wallhagen, M.I. & Cohen, R., Successful aging and well-being: Self-rated compared with Rowe and Kahn, The Gerontologist)*. Aging is an important part of all human societies which not only reflects the biological changes that occur, but also the cultural and societal conventions *(Masoro E.J. & Austad S.N.. eds: Handbook of the Biology of Aging, Sixth Edition. Academic Press. San Diego, CA, USA)*.

Population
The demographics of aging continue to change dramatically. The older population is growing rapidly, and the aging of the "Baby Boomers" born between 1946 and 1964, are accelerating this growth. This large population of older Americans will be more racially diverse and better educated than previous generations. Another significant trend is the increase in the proportion of men age 85 and over who are veterans.

In 2010, there were 40 million people age 65 and over in the United States, accounting for 13 percent of the total population. The older population in 2030 is projected to be twice as large as in 2000, growing from 35 million to 72 million and representing nearly 20 percent of the total U.S.

"WHAT DOES THIS MEAN FOR MY PRACTICE?

If you serve 100 adults 65 and older, it is likely that 20 of them have a behavioral health condition.

population (See "Indicator 1: Number of Older Americans").

INDICATOR 1   Number of Older Americans

The growth of the population age 65 and over affects many aspects of our society, challenging families, businesses, health care providers, and policymakers, among others, to meet the needs of aging individuals.

Population age 65 and over and age 85 and over, selected years 1900–2010 and projected 2020–2050

NOTE: These projections are based on Census 2000 and are not consistent with the 2010 Census results. Projections based on the 2010 Census will be released in late 2012.

Reference population: These data refer to the resident population.

SOURCE: U.S. Census Bureau, 1900 to 1940, 1970, and 1980, U.S. Census Bureau, 1983, Table 42; 1950, U.S. Census Bureau, 1953, Table 38; 1960, U.S. Census Bureau, 1964, Table 155; 1990, U.S. Census Bureau, 1991, 1990 Summary Table File; 2000, U.S. Census Bureau, 2001, *Census 2000 Summary File 1*; U.S. Census Bureau, Table 1: Intercensal Estimates of the Resident Population by Sex and Age for the U.S.: April 1, 2000 to July 1, 2010 (US-EST00INT-01); U.S. Census Bureau, 2011. *2010 Census Summary File 1*; U.S. Census Bureau, Table 2: Projections of the population by selected age groups and sex for the United States: 2010–2050 (NP2008-t2).

In 1965, 24 percent of the older population had graduated from high school, and only 5 percent had at least a Bachelor's degree. By 2010, 80 percent were high school graduates or more, and 23 percent had a Bachelor's degree or more.

Economics
There have been decreases in the proportion of older people living in poverty or in the low-income group just above the poverty line, both in recent years and over the longer term. Among older Americans, the share of income coming from earnings has increased since the mid-1980s, partly because more people, especially women, continue to work past age 55. In addition, net worth has increased almost 80 percent, on average, for older Americans.

Although most older Americans live in adequate, affordable housing, some live in costly, physically inadequate, or crowded housing. Additionally, major inequalities continue to exist: older blacks and people without high school diplomas report smaller economic gains and fewer financial resources overall.

Over the past four decades, labor force participation rates have risen for women age 55 and over. This trend continued during the recent recession. Among men age 55 and over, the rise in participation rates that started in the mid-1990s also has continued, although to a smaller extent. As "Baby Boomers" approach older ages, they are remaining in the labor force at higher rates than previous generations (See "Indicator 11: Participation in the Labor Force").

In recent years, approximately 40 percent of older American households had housing cost burden (expenditures on housing and utilities that exceed 30 percent of household income). In addition to having cost burden as the most dominant housing problem, crowded housing was also fairly prevalent for some older American households with children in their homes.

Health Status
Americans are living longer than ever before, yet their life expectancies lag behind those of other developed nations. Death rates for certain diseases have declined over time, while others have increased. Older age is often accompanied by increased risk of certain diseases and disorders. Large proportions of older Americans report a variety of chronic health conditions such as hypertension and arthritis. Nevertheless, most people age 65 and over report their health as good, very good, or excellent.

Life expectancy at age 65 in the United States was lower than that of many other industrialized nations. Women age 65 in Japan could expect to live on average 3.7 years longer than women in the United States. Among men, the difference was 1.3 years. Death rates for heart disease and stroke have declined by slightly more than 50 percent since 1981. Death rates for chronic lower respiratory disease increased by 57 percent in the same time period.

The prevalence of certain chronic conditions differ by sex. Women report higher levels of arthritis than men (56 percent versus 45 percent). Men report higher levels of heart disease (37 percent versus 26 percent).

In recent years, 76 percent of people age 65 and over rated their health as good, very good, or excellent. Non-Hispanic Whites were more likely to report good health than their non-Hispanic Black or Hispanic counterparts.

Health Risks and Behaviors
Social and lifestyle factors can affect the health and well-being of older Americans. These factors include preventive behaviors such as cancer screenings and routine vaccinations along with diet, physical activity, obesity, and cigarette smoking. The quality of the air where people live also affects health. Many of these health risks and behaviors have shown long-term improvements, even though recent estimates indicate no significant changes.

The proportion of leisure time that older Americans spent socializing and communicating—such as visiting friends or attending or hosting social events—declined with age. For Americans age 55–64, about 11 percent of leisure time was spent socializing and communicating compared with 8 percent for those age 75 and over.

End of Life
In the last decade there has been a substantial rise in the use of hospice services among older Americans. During that time, there has also been a smaller increase in the use of intensive care unit (ICU) and coronary care unit (CCU) services at the end of life. The percent of deaths among older Americans that occurred in hospitals declined over the last 20 years, with an increase in the percent dying at home.

With improved diet, physical fitness, public health, and health care, more adults are reaching age 65 in better physical and mental health than in the past. Trends show that the prevalence of chronic disability among older people is declining. While some disability is the result of more general losses of physiological functions with aging (i.e., normal aging), extreme disability in older persons, including that which stems from mental disorders, is not an inevitable part of aging (*Cohen, Rowe & Kahn*). Normal aging is a gradual process that ushers in some physical decline, such as decreased sensory abilities (e.g., vision and hearing) and decreased pulmonary and immune function (*Miller, Carman*). With aging come certain changes in mental functioning, but very few of these changes match

commonly held negative stereotypes about aging (Cohen, Rowe & Kahn). In normal aging, important aspects of mental health include stable intellectual functioning, capacity for change, and productive engagement with life. Cognition subsumes intelligence, language, learning, and memory. With advancing years, cognitive capacity with aging undergoes some loss, yet important functions are spared. Moreover, there is much variability between individuals, variability that is dependent upon lifestyle and psychosocial factors (Gottlieb). Most importantly, accumulating evidence from human and animal research finds that lifestyle modifies genetic risk in influencing the outcomes of aging (Finch & Tanzi). This line of research is beginning to dispel the pejorative stereotypes of older people as rigidly shaped by heredity and incapable of broadening their pursuits and acquiring new skills.

Cognitive Impact

Deterioration and/or decline occur in many cognitive processes throughout the lifespan. A great deal of research has focused on memory and aging, and has found decline in many types of memory with aging, but not in semantic memory or general knowledge such as vocabulary definitions, which typically increases or remains steady. Early studies on changes in cognition with age generally found declines in intelligence in the elderly, but studies were cross-sectional rather than longitudinal and thus results may be an artifact of cohort rather than a true example of decline. Intelligence may decline with age, though the rate may vary depending on the type, and may in fact remain steady throughout most of the lifespan, dropping suddenly only as people near the end of their lives. Individual variations in rate of cognitive decline may therefore be explained in terms of people having different lengths of life *(Mather, M., & Carstensen, L. L., Aging and motivated cognition: The positivity effect in attention and memory. Trends in Cognitive Sciences).*

Racial and Ethnic Minority Groups

One-fifth of older adults are currently members of racial or ethnic minority groups (8% African American, 7% Hispanic/Latino, 3% Asian, and 1% AI/AN, Native Hawaiian, or Pacific Islander), and it is projected that 42% of the older adult population will be members of racial or ethnic minority groups by 2050. Substantial work is needed to identify diverse groups of older adults and engage them in behavioral health services. It is estimated that up to one-fifth of older adults (5.6 to 8 million people) are experiencing one or more mental health or substance use conditions. Older women are more likely to have a mental health disorder, and older men are more likely

to have a substance misuse/abuse disorder. The rate of suicide among older men surpasses the rate among older women, and the suicide rate of Caucasian men ages 85 and older is more than four times the national rate.

The prevalence of behavioral health conditions differs across and within racial and ethnic groups of older adults. Differences may be explained by factors such as immigration status, gender, education and income levels, perceived financial strain, life events, and region of the country.

For example:

- One study found that, among Latinos and Latinas, acculturation is positively correlated with large and frequent alcohol consumption and high rates of drug abuse.

- A recent secondary analysis of the National Institute of Mental Health Collaborative Psychiatric Epidemiological Studies data set compared the rates of lifetime and 12-month psychiatric disorders among several older adult populations. The analysis found that the rates of depressive disorders are significantly higher among Latinos than the rates are among non-Latinos, attesting to the increased illness burden of common mental disorders among Latinos.

Table 1. Lifetime and 12-Month Prevalence Rates of Mental Disorders Among Older Adults

	Caucasians (N = 831)	Latinos (N = 420)	Asians (N = 260)	African Americans (N = 671)	Afro Caribbeans (N = 193)
Depressive Disorder, Lifetime	12.2%	16.4%	7.7%	5.4%	8.1%
Anxiety Disorder, Lifetime	13.5%	15.3%	10.9%	11.9%	11.2%
Depressive Disorder, past 12 months	3.2%	8.0%	2.1%	2.3%	4.6%
Anxiety Disorder, past 12 months	5.6%	6.8%	7.0%	6.6%	1.a%

Source: Jimenez DE, Alegría M, et al. (2010). Prevalence of psychiatric illnesses in older ethnic minority adults. *Journal of the American Geriatrics Society,* 58, 256–264.

- Behavioral health conditions are less prevalent among African Americans ages 55 and older who live in the South, compared with those living in other regions of the country.

- Major depression is more prevalent among Cuban Americans and Puerto Ricans between ages 65 and 74 than it is among Mexican

Americans in the same age group, and the rate is higher among Puerto Ricans ages 75 and older than it is for other similar-aged older Latino subgroups.

• Major depression is more prevalent among Chinese Americans between ages 65 and 74 compared with Filipino and Vietnamese Americans of the same age, but it is less prevalent among Chinese Americans ages 75 and older compared with similarly aged Filipino and Vietnamese Americans.

• When compared with older Caucasians, elderly AI/AN populations have higher rates of chronic diseases, such as diabetes and liver and kidney diseases, which are exacerbated with drinking.

• Despite the need for mental health services, older African Americans and Latinos are not seeking mental health services at the same rate as their non-Latino Caucasian counterparts. Results of a study of disparities in mental health service use showed that treatment initiation and adequacy were lower for older Latinos and African Americans than they were for older non-Latino Caucasians. These disparities persist even after adjusting for need (mental and physical health conditions), demographic characteristics (e.g., socio-economic status, education level), and insurance coverage.

• Beliefs about the causes of mental illness and stigma associated with mental health services may explain some disparities in the rates of use of mental health services among elderly racial/ethnic minorities. Analyses of baseline data collected for the Primary Care Research in Substance Abuse and Mental Health for the Elderly study indicate that African Americans view the loss of family and friends, stress over money, and general stress or worry as the primary causes of their mental disorders. Asian Americans believe that mental disorders are caused by medical illness, cultural differences, and family issues. Latinos believe that the loss of family and friends, family issues, and migration cause mental disorders. In addition, a greater proportion of older Latinos expressed more shame or embarrassment for having a mental disorder than other older populations, and more Latinos felt that people would think differently of them if they sought mental health treatment than did their non-Latino Caucasian counterparts.

- The rates of depression, suicidality, and substance (particularly alcohol and tobacco) misuse are higher in the older LGBT population than they are in the overall aging population. Although data are limited, a large study of LGBT individuals found that 31% were depressed. There appears to be an elevated risk of suicide attempts and suicidality among older gay men and lesbians and high rates of victimization. Rates of heavy drinking and smoking are reported to be much higher among LGBT older adults compared with the older population as a whole.

- Older adults living in rural areas have a much higher prevalence of major mental disorders, including high rates of depression, suicidality, and alcohol problems, than do other older populations. One reason for this is the difficulty of providing services in rural settings.

Reaching Older Adults and Engaging Them in Prevention Services and Early Interventions

Reaching older adults and engaging them in services to prevent and address depression and substance abuse can be challenging. The high prevalence of certain mental disorders, low use of mental health services, differing beliefs about mental health issues, and the stigma associated with mental illness illustrate the need to create culturally appropriate interventions for older racial/ethnic minorities. To address these challenges, effective, nontraditional approaches are likely needed such as:

- Providing education on prevention of behavioral health conditions;
- Providing universal and selective screening for depression, alcohol use, and psychoactive medication use/misuse;
- Training community members to be gatekeepers who can identify and refer at-risk older adults to behavioral health providers;
- Recruiting organizations trusted by leaders of the target population to conduct outreach in partnership with aging services, primary care, and behavioral health programs.

When applied within the context of culturally appropriate language and norms, the following strategies can be effective in reducing barriers to care and increasing engagement of older

adults:

- Using nonjudgmental motivational approaches;
- Empowering and engaging the older adult in decision-making;
- Avoiding stigmatizing terms (e.g., alcoholic, addict);
- Working with older adults in the setting they prefer (e.g., primary care, senior center, home);
- Using an active "warm hand-off" from the primary clinician to the person addressing behavioral health concerns;
- Engaging professionals who have a trusted relationship with the older adult;
- Taking an educational prevention/intervention approach to engaging the older adult;
- Addressing physical barriers (e.g., providing assistance with transportation); and
- Tailoring approaches to cultural views while maintaining fidelity to essential components of evidence-based practices.

Cultural Competence
The culture from which people come affects all aspects of behavioral health and illness, including the types of stresses they confront, whether they seek help, the types of help they seek, the symptoms and concerns they bring to clinical attention, and the types of coping styles and social supports they possess. Culture also affects individuals' exposures to behavioral health risk factors, health status, and the quantity and quality of health care resources available to them. Cultural considerations include race and ethnicity, country of origin, gender, sexual orientation, age cohort, religious affiliation, and physical and cognitive ability.

For the individual provider, cultural competence involves awareness and acceptance of difference, awareness of one's own cultural values, understanding the dynamics of difference, development of cultural knowledge, and ability to adapt practice to the cultural context of the client. For the provider organization, culturally sensitive elements include valuing diversity, conducting self-assessment, managing for the dynamics of difference, institutionalizing cultural knowledge, and adapting policies, structures, and services.

Competence at addressing diverse cultures can support and strengthen behavioral health services. Older adults and their providers can build on the

skills that older adults have developed over their lifetime. Many older adults have learned important ways of coping with life's stressors and have developed impressive resilience that is informed not only by their experiences but also by specific cultural beliefs and values.

The extent to which an organization's behavioral health services are culturally appropriate and relevant affects its quality of care, service usage, rate of treatment dropout, and health care outcomes. "Cultural competency is one of the main ingredients in closing the disparities gap in health care." Therefore, it is critical to ensure that the design, adaptation, training, and delivery of behavioral health services are culturally relevant. Many aging services, behavioral health and primary care providers, community leaders, and consumers have learned how to adapt proven outreach and engagement strategies and evidence-based behavioral health interventions to improve health outcomes with diverse groups of older adults.

Defining Cultural Terms
  ➢ **Culture**: Integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.
  ➢ **Competence:** Capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.
  ➢ **Cultural and linguistic competence:** A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.

Many community organizations provide culturally appropriate behavioral health services to older adults. These organizations include aging services providers, behavioral health providers, community centers, and counseling centers. Examples of strategies and adaptations that organizations have made to improve outreach to and engagement of specific groups of older adults are listed below.

Area Agency on Aging
(AAA) Offers behavioral
health services with cultural

adaptions
http://www.esmv.org/specializedservices.

Suicide Prevention Call
Service engages older men
Professional counseling and referrals are also available.
http://www.eldercommunitycare.org/index.htm

Alcohol and Drug Council
Engages older African Americans
www.council-houston.org/family-friends/seniors-2/

Senior Center
Engages older African Americans with Depression
Information about Beat the Blues Training is available from
Laura Gitlin, PhD, at Johns Hopkins University
lgitlin1@jhu.edu

Community Center
Addresses Depression in older Latinos
http://www.unitedcc.org/Default/ProgramsServices/HumanServices/

Stigma
In American society, where youth is highly valued, growing old and experiencing a mental illness at the same time can impose barriers to getting better and living a valued and productive life because society, institutions, and individuals, knowingly or unknowingly, stigmatize and discriminate against older adults with mental illnesses. SAMHSA has convened two roundtables of mental health services consumers, researchers, older adults, media representatives, grant writers, advocates, and practitioners. In the roundtables the participants discussed four topics:

• Research findings on older adults and mental health
• Manifestations of stigma and discrimination
• Barriers to eliminating stigma
• Strategies to overcome the barriers.

Research Findings on Older Adults and Mental Health

Demographic trends tell us that the number of older adults with mental illnesses will climb in the next 15 years, but research shows that the stigma of having a mental illness is getting worse, not better. The Indiana Consortium for Mental Health Services Research Project (*Pescosolido et al.*) found that over the past 40 years, Americans have acquired a greater and more sophisticated knowledge of mental illnesses. Americans are able to identify different types of mental illness, and many believe that treatment works. In that time, however, the stigma has intensified in some ways. About three-quarters of Americans do not want to work alongside someone with a mental illness nor do they wish such a person to marry into their family (*Pescosolido et al.*). More people today believe that someone with a mental illness is dangerous to himself or herself and to others than they did in the 1950s, the research found (*Pescosolido et al.*).

Manifestations of Stigma and Discrimination

Roundtable participants identified three types of stigma and discrimination:

➢ **Self-stigma-**older adults may be fearful of acknowledging their own mental illnesses;

➢ **Public stigma-**providers, employers, and the general public view older adults with;

➢ **Mental illnesses-**as people who will not get better with treatment, or worse, people who are not worth treating;

➢ **Institutional stigma-**assumptions about older adults with mental illnesses are translated into public policy and funding decisions that stigmatize and discriminate against these individuals.

2. Long Term Care

Long-Term Care Services

Long-term care services include a broad range of health, personal care, and supportive services that meet the needs of frail older people and other adults whose capacity for self-care is limited because of a chronic illness; injury; physical, cognitive, or mental disability; or other health-related conditions. Historically, the term "long-term care" has been used to refer to services and supports to help frail older adults and younger persons with disabilities maintain their daily lives. Recently, alternative terms have gained wider use, including "long-term services and supports." The Patient Protection and Affordable Care Act *(ACA, P.L. 111-148, as amended*) uses the term "long-

term services and supports" and defines the term to include certain institutionally based and non-institutionally based long-term services and care services to reflect both the changing vocabulary and the fact that these services can include both health care-related and non-health care-related services.

Long-term care services include assistance with activities of daily living (ADLs; dressing, bathing, and toileting), instrumental activities of daily living (IADLs; medication management and housework), and health maintenance tasks. Long-term care services assist people to improve or maintain an optimal level of physical functioning and quality of life, and can include help from other people and special equipment or assistive devices. The need for long-term care services is generally defined based on functional limitations (need for assistance with or supervision in ADLs and IADLs) regardless of cause, age of the person, where the person is receiving assistance, whether the assistance is human or mechanical, and whether the assistance is paid or unpaid.
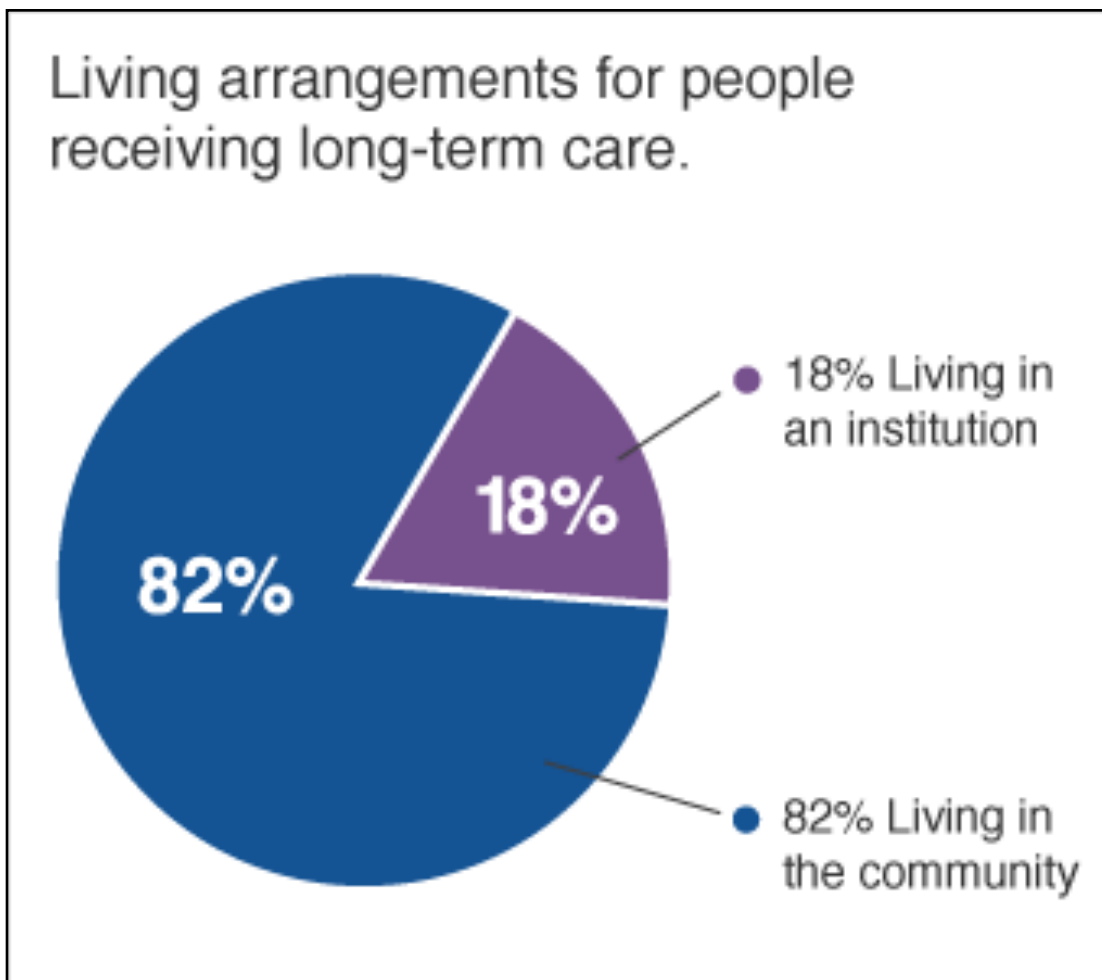
Individuals may receive long-term care services in a variety of settings:

- In the community, such as at an adult day services center in the home, for example, from a home health agency, hospice, or family and friends
- In institutions, such as in a nursing home or skilled nursing facility
- In other residential settings, for instance, in an assisted living or similar residential care community.

The most common type of long-term care is personal care—help with everyday activities, also called "activities of daily living." These activities include bathing, dressing, grooming, using the toilet, eating, and moving around—for example, getting out of bed and into a chair.

Long-term care also includes community services such as meals, adult day care, and transportation services. These services may be provided free or for a fee.

People often need long-term care when they have a serious, ongoing health condition or disability. The need for long-term care can arise suddenly, such as after a heart attack or stroke. Most often, however, it develops gradually, as people get older and frailer or as an illness or disability gets worse.

Living arrangements for people receiving long-term care.

- 18% Living in an institution
- 82% Living in the community

18%

82%

Home-Based Long-Term Care Services

Home-based long-term care includes health, personal, and support services to help people stay at home and live as independently as possible. Most long-term care is provided either in the home of the person receiving services or at a family member's home. In-home services may be short-term —for someone who is recovering from an operation, for example—or long-term, for people who need ongoing help.

Most home-based services involve personal care, such as help with bathing, dressing, and taking medications, and supervision to make sure a person is safe. Unpaid family members, partners, friends, and neighbors provide most of this type of care.

Home-based long-term care services can also be provided by paid caregivers, including caregivers found informally, and healthcare

professionals such as nurses, home health care aides, therapists, and homemakers, who are hired through home health care agencies. These services include: home health care, homemaker services, friendly visitor/companion services, and emergency response systems.

Home Health Care

Home health care involves part-time medical services ordered by a physician for a specific condition. These services may include nursing care to help a person recover from surgery, an accident, or illness. Home health care may also include physical, occupational, or speech therapy and temporary home health aide services. These services are provided by home health care agencies approved by Medicare, a government insurance program for people over age 65.

Homemaker and Personal Care Services

Home health agencies offer homemaker and personal care services that can be purchased without a physician's order. Homemaker services include help with meal preparation and household chores. Personal care includes help with bathing and dressing. Agencies do not have to be approved by Medicare to provide these kinds of services.

Friendly Visitor and Senior Companion Services

Friendly visitor/companion services are usually staffed by volunteers who regularly pay short visits (less than 2 hours) to someone who is frail or living alone. You can also purchase these services from home health agencies.

Senior Transportation Services

Transportation services help people get to and from medical appointments, shopping centers, and other places in the community. Some senior housing complexes and community groups offer transportation services. Many public transit agencies have services for people with disabilities. Some services are free. Others charge a fee. Learn more about transportation services from the Eldercare Locator.

Emergency Medical Alert Systems

Emergency response systems automatically respond to medical and other emergencies via electronic monitors. The user wears a necklace or bracelet with a button to push in an emergency. Pushing the button summons

emergency help to the home. This type of service is especially useful for people who live alone or are at risk of falling. A monthly fee is charged.

Making Financial Decisions for Long-Term Care

Long-term care can be expensive. Americans spend billions of dollars a year on various services. How people pay for long term care depends on their financial situation and the kinds of services they use. Often, they rely on a variety of payment sources, including:

- Personal funds, including pensions, savings, and income from stocks
- Government health insurance programs, such as Medicaid (Medicare does not cover long-term care but may cover some costs of short-term care in a nursing home after a hospital stay.)
- Private financing options, such as long-term care insurance
- Veterans' benefits
- Services via the Older Americans Act

To find home-based services, contact Eldercare Locator at **1-800-677-1116** or visit https://eldercare.acl.gov. Or call the local Area

Agency on Aging, Aging and Disability Resource Center, department of human services or aging, or a social service agency.

It is difficult to predict how much or what type of long-term care a person might need. Several things increase the risk of needing long-term care.

- **Age.** The risk generally increases as people get older.
- **Gender.** Women are at higher risk than men, primarily because they often live longer.
- **Marital status.** Single people are more likely than married people to need care from a paid provider.
- **Lifestyle.** Poor diet and exercise habits can increase a person's risk.
- **Health and family history.** These factors also affect risk.

Residential Facilities, Assisted Living, and Nursing Homes

At some point, support from family, friends, and local programs may not be enough. People who require help full-time might move to a residential facility that provides many or all of the long-term care services they need.

Facility-based long-term care services include: board and care homes, assisted living facilities, nursing homes, and continuing care retirement communities.

Some facilities have only housing and housekeeping, but many also provide personal care and medical services. Many facilities offer special programs for people with Alzheimer's disease and other types of dementia.

Board and Care Homes

Board and care homes, also called residential care facilities or group homes, are small private facilities, usually with 20 or fewer residents. Rooms may be private or shared. Residents receive personal care and meals and have staff available around the clock. Nursing and medical care usually are not provided on site.

Assisted Living

Assisted living is for people who need help with daily care, but not as much help as a nursing home provides. Assisted living facilities range in size from as few as 25 residents to 120 or more. Typically, a few "levels of care" are offered, with residents paying more for higher levels of care.

Assisted living residents usually live in their own apartments or rooms and share common areas. They have access to many services, including up to three meals a day; assistance with personal care; help with medications, housekeeping, and laundry; 24-hour supervision, security, and on-site staff; and social and recreational activities. Exact arrangements vary from state to state.

Nursing Homes

Nursing homes, also called skilled nursing facilities, provide a wide range of health and personal care services. Their services focus on medical care more than most assisted living facilities. These services typically include nursing care, 24-hour supervision, three meals a day, and assistance with everyday activities. Rehabilitation services, such as physical, occupational, and speech therapy, are also available.

Some people stay at a nursing home for a short time after being in the hospital. After they recover, they go home. However, most nursing home residents live there permanently because they have ongoing physical or mental conditions that require constant care and supervision.

Continuing Care Retirement Communities (CCRCs)

Continuing care retirement communities (CCRCs), also called life care communities, offer different levels of service in one location. Many of them offer independent housing (houses or apartments), assisted living, and skilled nursing care all on one campus. Healthcare services and recreation programs are also provided.

In a CCRC, where you live depends on the level of service you need. People who can no longer live independently move to the assisted living facility or sometimes receive home care in their independent living unit. If necessary, they can enter the CCRC's nursing home.

There are many sources of information about facility-based long-term care. A good place to start is the Eldercare Locator at **1-800-677-1116** or https://eldercare.acl.gov. Another resource is the local Area Agency on Aging, Aging and Disability Resource Center, department of human services or aging, or a social service agency.

For More Information About Facility-Based Long-Term Care

Centers for Medicare & Medicaid Services
800-633-4227 (toll-free)
877-486-2048 (TTY/toll-free)
https://www.cms.gov/
www.medicare.gov

Eldercare Locator
800-677-1116 (toll-free)
eldercarelocator@n4a.org
https://eldercare.acl.gov

National Association of Area Agencies on Aging
202-872-0888
info@n4a.org
www.n4a.org

Paying for LTC

Finding a way to pay for long-term care services is a growing concern for older adults, persons with disabilities, and their families, and is a major challenge facing state and federal governments. Medicaid finances a major portion of paid, long-term care services, followed by Medicare and out-of-pocket payments by individuals and families. However, the distribution of financing sources varies by provider sector and by population. For example, most residents pay out-of-pocket for assisted living, with a small percentage using Medicaid to help pay for services. In contrast, the largest single payer for long-term nursing home care is Medicaid, whereas Medicare finances hospice costs and a major portion of the costs for short-stay, post-acute care in skilled nursing facilities for Medicare beneficiaries (Federal Interagency Forum on Aging-Related Statistics). The number of people using nursing facilities, alternative residential care places, or home care services is projected to increase from 15 million in 2000 to 27 million in 2050. Most of this increase will be due to growth in the older adult population who need

such services (*HHS*). Although people of all ages may need long-term care services, the risk of needing these services increases with age. Recent projections estimate that over two-thirds of individuals who reach age 65 will need long-term care services during their lifetime (*Kemper, Komisar, & Alecxih*). Largely due to aging baby boomers, the population is expected to become much older, with the number of Americans over age 65 projected to more than double, from 40.2 million in 2010 to 88.5 million in 2050 (*Vincent & Velkoff*). The estimated increase in the number of the "oldest old" —those aged 85 and over—is even more striking. The oldest old are projected to almost triple, from 6.3 million in 2015 to 17.9 million in 2050, accounting for 4.5% of the total population *(U.S. Census Bureau)*.

This oldest old population tends to have the highest disability rate and need for long-term care services, and they also are more likely to be widowed and without assistance with ADLs (*Feder & Komisar,; Houser, Fox-Grage, & Ujvar*i). Decreasing family size and increasing employment rates among women may reduce the traditional pool of family caregivers, further stimulating demand for paid long-term care services (*Congressional Budget Office*). Among persons who need long-term care services, adults aged 65 and over are more likely than younger adults to receive paid help (*Kaye, Harrington, & LaPlante*). Recent studies project that the number of older adults using paid, long-term care services will grow substantially (*Johnson, Toohey, & Wiener, Kaye)*. A substantial share of paid, long-term care services is publicly funded through programs such as Medicaid and Medicare; accurate, timely statistical information can help guide those programs and inform relevant policy decisions.

The National Study of Long-Term Care Providers

The long-term care services delivery system in the United States has changed substantially over the last 30 years. For example, although nursing homes are still a major provider of long-term care services, there is growing use of skilled nursing facilities for short-term, post-acute care and rehabilitation (*Decker*). Further, consumers' desire to stay in their own homes, and federal and state policy developments (e.g., the Supreme Court's Olmstead ruling, introduction of the Medicare Prospective Payment System, and balancing Medicaid-financed services from institutional to non-institutional settings) have led to growth in a variety of home- and community-based alternatives (*Doty, Wiener*). The major sectors of paid, long-term care services providers now also include adult day services

centers, assisted living and similar residential care communities, home health agencies, and hospices.

Long-term care services provided by paid regulated providers are an important component of personal health care spending in the United States. Estimates of expenditures for paid long-term care services vary, depending on what types of providers, populations, and services are included. According to a recent estimate, total national spending for paid long-term care services was almost $339 billion, with public spending accounting for about 72% of this amount. The cost of long-term care services varies by the type of paid care provided and the type of provider or sector (e.g., adult day services centers, assisted living and similar residential care communities, home health agencies, or hospices). Finding a way to pay for long-term care services is a growing concern for older adults, other persons with disabilities, and their families, and it is a major challenge facing state and federal governments. People who use paid long-term care services, through home and community-based services or institutional care, are among the most costly participants in Medicare and Medicaid programs. Medicaid finances the largest portion of paid long-term care services, followed by Medicare, out-of-pocket payments by individuals and families, other private sources, private insurance, and other public programs.

Medicaid finances a variety of long-term care services through multiple mechanisms (e.g., Medicaid State Plan, home and community-based services waiver program, and other options for community-based long-term care services), including an array of home and community-based services and institutional services.

Experts disagree on whether Medicare expenditures for skilled nursing facilities and home health agencies, since they are post-acute services, should be considered long-term care services. This section includes Medicare-certified skilled nursing facilities and home health agencies, which are often referred to as post-acute care services.

The distribution of the different financing sources described previously varies by long-term care services sector and population. For example, most residents pay out of pocket for assisted living and similar residential care communities, with a small percentage using Medicaid to help pay for services. In contrast, the largest single payer for long-term nursing home care is Medicaid, whereas Medicare finances hospice costs and a major portion of the costs for short-stay post-acute care in skilled nursing facilities for Medicare beneficiaries.

Although people of all ages may need long-term care services, the risk of needing these services increases with age. The number of Americans over age 65 is projected to shift from 47.8 million in 2015 to over 87.9 million in 2050, representing an increase of 84% and comprising 22% of the population. The population aged 85 and over is projected to triple, from 6.3 million in 2015 to over 18.9 million in 2050, and will account for almost 5% of the U.S. population. This "oldest old" population tends to have the highest disability rate and highest need for long-term care services, and is also more likely to be widowed and without someone to provide assistance with daily activities. The number of older people in the United States with significant physical or cognitive disabilities is projected to increase from 6.3 million in 2015 to 15.7 million in 2065.

Decreasing family size and increasing employment rates among women may reduce the traditional pool of family caregivers, further stimulating demand for paid long-term care services. Among persons who need long-term care services, adults aged 65 and over are more likely than younger adults to receive paid help. Results from the National Health and Aging Trends study show that of the 10.9 million older adults who reported receiving help with daily activities in a given month, about 3 in 10 received paid help. Recent projections using microsimulation modeling estimate that about one-half of Americans reaching age 65 will need long-term care services and will incur, on average, $138,000 in long-term care costs. The average projected length of needing long-term Providers

The long-term care services delivery system in the United States has changed substantially over the last 30 years. For example, although nursing homes are still a major provider of long-term care services, there has been growing use of skilled nursing facilities for short-term post-acute care and rehabilitation. Additionally, consumers' desire to stay in their own homes, as well as federal and state policy developments, have led to growth in a variety of home and community-based alternatives. Examples of these federal and state policy developments include the Supreme Court's Olmstead decision; introduction of the Medicare Prospective Payment System; and a variety of initiatives to encourage balancing of Medicaid-financed services from institutional to non-institutional settings, such as Money Follows the Person, Community First Choice Option, and the Balancing Incentives Payment Program.

The major sectors of paid long-term care services providers now also include adult day services centers, assisted living and similar residential care communities, home health agencies, and hospices.

3. Aging and Mental Health

Research Findings on Older Adults and Mental Health
The roundtables reviewed the research findings on older adults and mental health. Many facts were found that must be taken into account when developing action plans for the future of mental health care for older adults. Some of the trends for older adults and mental illnesses are illustrated here.

Mental Illnesses in Older Adults
It is estimated that by 2030, more than 15 million older adults will experience a mental illness. That is nearly double the current number (*Jeste et al.*). These projections are largely based on the aging of the "baby boomer" cohort and greater longevity. Prevalence of Mental Disorders at Age 65+One-quarter of today's older adults experience some mental disorder, including dementia. About 16 percent have psychiatric disorders, and about 10 percent have dementia. A third of those with dementia exhibit psychosis and/or depression, and they represent about 3 percent of the total elderly population (*Jeste et al.*).

Depression is Associated with Worse Health Outcomes
Depression can strike an older adult after he or she has suffered a hip fracture or heart attack or has been diagnosed with cancer; as a result of these co-occurring illnesses, older adults are at increased risk of poor recovery (*Mossey et al., Penninx et al., Evans et al.*). Mortality rates also increase for those with depression and myocardial infarction and those with depression who are long-term care residents. In general, older adults with mental illnesses experience high medical co-morbidity.

Depression in Older Adults and Health Care Costs
Older adults with significant depression have total health care costs that are roughly 50 percent higher than those without depression. They have a higher use of services in all categories of medical care, including inpatient admissions, outpatient visits, laboratory tests, emergency department visits, the number of prescriptions, and ancillary and optometry visits (*Unützer et al.*).

Key Facts
✦ Mental health and well-being are as important in older age as at any other time of life.

✦ Mental and neurological disorders among older adults account for 6.6% of the total disability (DALYs) for this age group.

✦ Approximately 15% of adults aged 60 and over suffer from a mental disorder.

Older adults make important contributions to society as family members, volunteers and as active participants in the workforce. While most have good mental health, many older adults are at risk of developing mental disorders, neurological disorders or substance use problems as well as other health conditions such as diabetes, hearing loss, and osteoarthritis. Furthermore, as people age, they are more likely to experience several conditions at the same time.

Over 20% of adults aged 60 and over suffer from a mental or neurological disorder (excluding headache disorders) and 6.6% of all disability (disability adjusted life years-DALYs) among people over 60 years is attributed to mental and neurological disorders. These disorders in older people account for 17.4% of Years Lived with Disability (YLDs). The most common mental and neurological disorders in this age group are dementia and depression, which affect approximately 5% and 7% of the world's older population, respectively. Anxiety disorders affect 3.8% of the older population, substance use problems affect almost 1% and around a quarter of deaths from self-harm are among people aged 60 or above. Substance abuse problems among older people are often overlooked or misdiagnosed. Mental health problems are underidentified by health care professionals and older people themselves, and the stigma surrounding these conditions makes people reluctant to seek help.

Risk Factors for Mental Health Problems Among Older Adults
There may be multiple risk factors for mental health problems at any point in life. Older people may experience life stressors common to all people, but also stressors that are more common in later life, like a significant ongoing loss in capacities and a decline in functional ability. For example, older adults may experience reduced mobility, chronic pain, frailty or other health problems, for which they require some form of long-term care. In addition, older people are more likely to experience events such as bereavement, or a drop in socioeconomic status with retirement. All of these stressors can

result in isolation, loneliness or psychological distress in older people, for which they may require long-term care.

Mental health has an impact on physical health and vice versa. For example, older adults with physical health conditions such as heart disease have higher rates of depression than those who are healthy. Additionally, untreated depression in an older person with heart disease can negatively affect its outcome.

Older adults are also vulnerable to elder abuse including physical, verbal, psychological, financial and sexual abuse; abandonment; neglect; and serious losses of dignity and respect. Current evidence suggests that 1 in 6 older people experience elder abuse. Elder abuse can lead not only to physical injuries, but also to serious, sometimes long lasting psychological consequences, including depression and anxiety.

Dementia and Depression Among Older People as Public Health Issues

Dementia

Dementia is a syndrome, usually of a chronic or progressive nature, in which there is deterioration in memory, thinking, behavior and the ability to perform everyday activities. It mainly affects older people, although it is not a normal part of aging. It is estimated that 50 million people worldwide are living with dementia with nearly 60% living in low- and middle-income countries. The total number of people with dementia is projected to increase to 82 million in 2030 and 152 million in 2050.

There are significant social and economic issues in terms of the direct costs of medical, social and informal care associated with dementia. Moreover, physical, emotional and economic pressures can cause great stress to families and carers. Support is needed from the health, social, financial and legal systems for both people with dementia and their carers.

Depression

Depression can cause great suffering and leads to impaired functioning in daily life. Unipolar depression occurs in 7% of the general older population and it accounts for 5.7% of YLDs among those over 60 years old.

Depression is both underdiagnosed and undertreated in primary care settings. Symptoms are often overlooked and untreated because they co-occur with other problems encountered by older adults.

Older people with depressive symptoms have poorer functioning compared to those with chronic medical conditions such as lung disease, hypertension or diabetes. Depression also increases the perception of poor health, the utilization of health care services and costs.

Treatment and Care Strategies to Address Mental Health Needs of Older People

It is important to prepare health providers and societies to meet the specific needs of older populations, including:

- Training for health professionals in providing care for older people;
- Preventing and managing age-associated chronic diseases including mental, neurological and substance use disorders;
- Designing sustainable policies on long-term and palliative care; and
- Developing age-friendly services and settings.

Health Promotion

The mental health of older adults can be improved through promoting Active and Healthy Aging. Mental health-specific health promotion for older adults involves creating living conditions and environments that support wellbeing and allow people to lead a healthy life. Promoting mental health depends largely on strategies to ensure that older people have the necessary resources to meet their needs, such as:

- Providing security and freedom;
- Adequate housing through supportive housing policy;
- Social support for older people and their caregivers;
- Health and social programs targeted at vulnerable groups such as those who live alone and rural populations or who suffer from a chronic or relapsing mental or physical illness;
- Programs to prevent and deal with elder abuse; and
- Community development programs.

Interventions

Prompt recognition and treatment of mental, neurological and substance use disorders in older adults is essential. Both psychosocial interventions and medicines are recommended.

There is no medication currently available to cure dementia but much can be done to support and improve the lives of people with dementia and their caregivers and families, such as:

- Early diagnosis, in order to promote early and optimal management;
- Optimizing physical and mental health, functional ability and well-being;
- Identifying and treating accompanying physical illness;
- Detecting and managing challenging behavior; and
- Providing information and long-term support to carers.

Mental Health Care in the Community

Good general health and social care is important for promoting older people's health, preventing disease and managing chronic illnesses. Training all health providers in working with issues and disorders related to aging is therefore important. Effective, community-level primary mental health care for older people is crucial. It is equally important to focus on the long-term care of older adults suffering from mental disorders, as well as to provide caregivers with education, training and support.

An appropriate and supportive legislative environment based on internationally accepted human rights standards is required to ensure the highest quality of services to people with mental illness and their caregivers.

WHO Response

WHO supports governments in the goal of strengthening and promoting mental health in older adults and to integrate effective strategies into policies and plans. The Global strategy and action plan on aging and health was adopted by the World Health Assembly in 2016. One of the objectives of this global strategy is to align the health systems to the needs of older populations, for mental as well as physical health. Key actions include: orienting health systems around intrinsic capacity and functional ability, developing and ensuring affordable access to quality older person-centred and integrated clinical care, and ensuring a sustainable and appropriately trained, deployed, and managed health workforce.

The Comprehensive Mental Health Action Plan for 2013-2020 is a commitment by all WHO Member States to take specific actions to promote mental well-being, prevent mental disorders, provide care, enhance recovery,

promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders including in older adults. It focuses on 4 key objectives to:

- Strengthen effective leadership and governance for mental health;
- Provide comprehensive, integrated and responsive mental health and social care services in community-based settings;
- Implement strategies for promotion and prevention in mental health; and
- Strengthen information systems, evidence and research for mental health.

Depression, psychoses, suicide, epilepsy, dementia and substance use disorders are included in the WHO Mental Health Gap Action Program (mhGAP) that aims to improve care for mental, neurological and substance use disorders through providing guidance and tools to develop health services in resource-poor areas. The mhGAP package consists of interventions for prevention and management for each of these priority conditions in non-specialized health settings including in those for older people.

In May 2017, the World Health Assembly endorsed the *Global action plan on the public health response to dementia 2017-2025*. The Plan provides a comprehensive blueprint for action – for policy-makers, international, regional and national partners, and WHO – in areas such as, increasing awareness of dementia and establishing dementia-friendly initiatives; reducing the risk of dementia; diagnosis, treatment and care; research and innovation; and support for dementia carers. It aims to improve the lives of people with dementia, their carers and families, while decreasing the impact of dementia on individuals, communities and countries. As part of the efforts to operationalize the Plan, an international surveillance platform, the Global Dementia Observatory, has been established for policy-makers and researchers to facilitate monitoring and sharing of information on dementia policies, service delivery, epidemiology and research.

Fortunately, the past 15 to 20 years have been marked by rapid growth in the number of clinical, research, and training centers dedicated to the mental illness- and mental health-related needs of older people. As evident in this section, much has been learned. The section reviews, first, normal developmental milestones of aging, highlighting the adaptive capacities that enable many older people to change, cope with loss, and pursue productive

and fulfilling activities. The section then considers mental disorders in older

The definition of **serious mental illnesses** (SMIs) includes one or more diagnoses of mental disorders combined with significant impairment in functioning. Schizophrenia, bipolar illness, and major depressive disorder are the diagnoses most commonly associated with SMI, but people with one or more other disorders may also fit the definition of SMI if those disorders result in functional impairment.[15]

Geriatric mental health workforce refers to the range of personnel providing services to older adults with mental health conditions.[5]

The terms "**older adult**" and "**geriatric population**" refer to individuals age 65 and older.[5]

Co-occurring Conditions

As a normal course of aging, older adults experience changes to their physical health, mental health, and cognitions. Interactions among these age-related factors can result in "spiral" or "cascade" of decline in physical, cognitive, and psychological health.[18]

A 2006 report of the National Association of State Mental Health Program Directors indicates that people with SMI die earlier than the general population and are at higher risk for multiple adverse health outcomes.[19] There may be a number of reasons.

Older adults with an SMI have substantially higher rates of diabetes, lung disease, cardiovascular disease, and other comorbidities that are associated with early mortality, disability, and poor function.[20] They also have significant impairments in psychosocial functioning.[21] Older adults with SMI account for disproportionately high costs and service use.[20,21] Lifestyle and behaviors (e.g., tobacco and alcohol use, sedentary) may put older adults with SMI at greater risk for metabolic side effects of antipsychotic medications and lead to obesity and chronic physical health conditions.[20]

Among older adults, the rate of substance use disorders is reported as .2 to 1.9 percent.[5,22,59] Approximately 1.4 percent of older women and 2.2 percent of older men reported past-year use of illicit drugs, including marijuana, cocaine, heroin, and prescription psychotherapeutic medications, such as pain relievers and antianxiety medications that are used for nonmedical purposes.[5] The 2016 National Survey of Drug Use and Health data indicate that there are approximately 863,000 older adults with a substance use disorder involving illicit drugs or alcohol, but only 240,000 (approximately 27 percent) received treatment for their substance use problem.[59] Prevalence rates for older-adult at-risk drinking (defined as more than 3 drinks per occasion; more than 7 drinks per week) are estimated to be 16.0 percent for men and 10.9 percent for women.[22] For individuals who are 50 years old and up, misuse of opioids is projected to be 2 percent.[24]

In 2013, more than 7,000 people age 65 or older died by suicide.[25] Suicide rates are particularly high among older men, although suicide attempts are more common among older women.[25] Suicide attempts are more likely to result in death among older adults than among younger people.[25]

Statistics Relevant to Older Adults with SMI

15% of older adults are impacted by behavioral health problems[16]

4.8% of older adults are living with a serious mental illness[5]

.2% ········▶ bipolar disorder[5]

.2 - .8% ······▶ schizophrenia[5]

3 - 4.5% ······▶ depression[5]

People aged 65 and older account for **17.9%** of suicide deaths[17]

people—their diagnosis and treatment, and the various risk factors that may complicate the course or outcome of treatment. Risk factors include co-occurring, or co-morbid, general medical conditions, the high numbers of medications many older individuals take, and psychosocial stressors such as bereavement or isolation. These are cause for concern, but, as the section notes, they also point the way to possible new preventive interventions. The goal of such prevention strategies may be to limit disability or to postpone or even eliminate the need to institutionalize an ill person (*Lebowitz & Pearson, in press*). The section reviews gains that have been realized in making appropriate mental health services available to older people and the challenges associated with the delivery of services to this population. The advantages of a decisive shift away from mental hospitals and nursing homes to treatment in community-based settings today are in jeopardy of being undermined by fragmentation and insufficient availability of such services (*Gatz & Smyer, Cohen & Cairl*). The section examines obstacles and opportunities in the service delivery sphere, in part through the lens of public and private sector financing policies and managed care. Finally, the section reviews the supports for older persons that extend beyond traditional, formal treatment settings. Through support networks, self-help groups, and other means, consumers, families, and communities are assuming an increasingly important role in treating and preventing mental health problems and disorders among older persons.

With improved diet, physical fitness, public health, and health care, more adults are reaching age 65 in better physical and mental health than in the past. Trends show that the prevalence of *chronic* disability among older people is declining (*Manton et al.*). While some disability is the result of more general losses of physiological functions with aging (i.e., normal aging), *extreme* disability in older persons, including that which stems from mental disorders, is not an inevitable part of aging (Cohen; Rowe & Kahn). Normal aging is a gradual process that ushers in some physical decline, such as decreased sensory abilities (e.g., vision and hearing) and decreased pulmonary and immune function *(Miller; Carman)*. With aging come certain changes in mental functioning, but very few of these changes match commonly held negative stereotypes about aging (*Cohen, Rowe & Kahn*). In normal aging, important aspects of mental health include stable intellectual functioning, capacity for change, and productive engagement with life.

Cognition

Cognition subsumes intelligence, language, learning, and memory. With advancing years, cognitive capacity with aging undergoes some loss, yet important functions are spared. Moreover, there is much variability between individuals, variability that is dependent upon lifestyle and psychosocial factors (*Gottlieb*). Most important, accumulating evidence from human and animal research finds that lifestyle modifies genetic risk in influencing the outcomes of aging (*Finch & Tanzi*). This line of research is beginning to dispel the pejorative stereotypes of older people as rigidly shaped by heredity and incapable of broadening their pursuits and acquiring new skills.

One large, ongoing longitudinal study found high cognitive performance to be dependent on four factors, ranked here in decreasing order of importance: education, strenuous activity in the home, peak pulmonary flow rate, and "self-efficacy," which is a personality measure defined by the ability to organize and execute actions required to deal with situations likely to happen in the future (*Albert et al.*).

Education, as assessed by years of schooling, is the strongest predictor of high cognitive functioning. This finding suggests that education not only has salutary effects on brain function earlier in life, but also foreshadows sustained productive behavior in later life, such as reading and performing crossword puzzles (*Rowe & Kahn*).

The coexistence of mental and somatic disorders (i.e., comorbidity) is common (*Kramer et al.*). Some disorders with primarily somatic symptoms can cause cognitive, emotional, and behavioral symptoms as well, some of which rise to the level of mental disorders. At that point, the mental disorder may result from an effect of the underlying disorder on the central nervous system (e.g., dementia due to a medical condition such as hypothyroidism) or an effect of treatment (e.g., delirium due to a prescribed medication). Likewise, mental problems or disorders can lead to or exacerbate other physical conditions by decreasing the ability of older adults to care for themselves, by impairing their capacity to rally social support, or by impairing physiological functions. For example, stress increases the risk of coronary heart disease and can suppress cellular immunity (*McEwen*). Depression can lead to increased mortality from heart disease and possibly cancer (*Frasure-Smith et al., Penninx et al.*).

A new model postulates that successful aging is contingent upon three elements: avoiding disease and disability, sustaining high cognitive and physical function, and engaging with life (*Rowe & Kahn*). The latter encompasses the maintenance of interpersonal relationships and productive activities, as defined by paid or unpaid activities that generate goods or services of economic value. The three major elements are considered to act in concert, for none is deemed sufficient by itself for successful aging. This new model broadens the reach of health promotion in aging to entail more than just disease prevention.

Descriptive research reveals evidence of the capacity for constructive change in later life (*Cohen*). The capacity to change can occur even in the face of mental illness, adversity, and chronic mental health problems. Older persons display flexibility in behavior and attitudes and the ability to grow intellectually and emotionally. Time plays a key role. Externally imposed demands upon one's time may diminish, and the amount of time left at this stage in life can be significant. In the United States in the late 20th century, late-life expectancy approaches another 20 years at the age of 65. In other words, average longevity from age 65 today approaches what had been the average longevity from birth some 2,000 years ago. This leaves plenty of time to embark upon new social, psychological, educational, and recreational pathways, as long as the individual retains good health and material resources. In his classic developmental model, Erik Erikson characterized the final stage of human development as a tension between "ego integrity and despair" (*Erikson*). Erikson saw the period beginning at age 65 years as highly variable. Ideally, individuals at this stage witness the flowering of seeds planted earlier in the prior seven stages of development. When they achieve a sense of integrity in life, they garner pride from their children, students and protégés, and past accomplishments. With contentment comes a greater tolerance and acceptance of the decline that naturally accompanies the aging process. Failure to achieve a satisfying degree of ego integrity can be accompanied by despair. Cohen (in press) has proposed that with increased longevity and health, particularly for people with adequate resources, aging is characterized by two human potential phases. These phases, which emphasize the positive aspects of the final stages of the life cycle, are termed *Retirement/Liberation* and *Summing Up/Swan Song*.

Retirement often is viewed as the most important life event prior to death. Retirement frequently is associated with negative myths and stereotypes

(*Sheldon et al. Bass*). Cohen points out, however, that most people fare well in retirement. They have the opportunity to explore new interests, activities, and relationships due to retirement's liberating qualities. In the Retirement/Liberation phase, new feelings of freedom, courage, and confidence are experienced. Those at risk for faring poorly are individuals who typically do not want to retire, who are compelled to retire because of poor health, or who experience a significant decline in their standard of living (Cohen). In short, the liberating experience of having more time and an increased sense of freedom can be the springboard for creativity in later life.

Creative achievement by older people can change the course of an individual, family, community, or culture. In the late-life Summing Up/Swan Song phase, there is a tendency to appraise one's life work, ideas, and discoveries and to share them with family or society. The desire to sum up late in life is driven by varied feelings, such as the desire to complete one's life work, the desire to give back after receiving much in life, or the fear of time evaporating. Important opportunities for creative sharing and expression ensue. There is a natural tendency with aging to reminisce and elaborate stories that has propelled the development of reminiscence therapy for health promotion and disease prevention. The swan song, the final part of this phase, connotes the last act or final creative work of a person before retirement or death.

There is much misunderstanding about thoughts of death in later life. Depression, serious loss, and terminal illness trigger the sense of mortality, regardless of age. Contrary to popular stereotypes, studies on aging reveal that most older people generally do not have a fear or dread of death in the absence of being depressed, encountering serious loss, or having been recently diagnosed with a terminal illness (*Kastenbaum*). Periodic thoughts of death—not in the form of dread or angst—do occur. But these are usually associated with the death of a friend or family member. When actual dread of death does occur, it should not be dismissed as accompanying aging, but rather as a signal of underlying distress (e.g., depression). This is particularly important in light of the high risk of suicide among depressed older adults, which is discussed later in this chapter.

Loss

Many older adults experience loss with aging—loss of social status and self-esteem, loss of physical capacities, and death of friends and loved ones. But in the face of loss, many older people have the capacity to develop new adaptive strategies, even creative expression (*Cohen*). Those experiencing loss may be able to move in a positive direction, either on their own, with the benefit of informal support from family and friends, or with formal support from mental health professionals. The life and work of William Carlos Williams are illustrative. Williams was a great poet as well as a respected physician. In his 60s, he suffered a stroke that prevented him from practicing medicine. The stroke did not affect his intellectual abilities, but he became so severely depressed that he needed psychiatric hospitalization. Nonetheless, Williams, with the help of treatment for a year, surmounted the depression and for the next 10 years wrote luminous poetry, including the Pulitzer Prize-winning *Pictures From Bruegel,* which was published when he was 79. In his later life, Williams wrote about "old age that adds as it takes away." What Williams and his poetry epitomize is that age can be the catalyst for tapping into creative potential (*Cohen*).

Loss of a spouse is common in late life. About 800,000 older Americans are widowed each year. Bereavement is a natural response to death of a loved one. Its features, almost universally recognized, include crying and sorrow, anxiety and agitation, insomnia, and loss of appetite (*Institute of Medicine [IOM]*). This constellation of symptoms, while overlapping somewhat with major depression, does not by itself constitute a mental disorder. Even though bereavement of less than 2 months' duration is not considered a mental disorder, it still warrants clinical attention. The justification for clinical attention is that bereavement, as a highly stressful event, increases the probability of, and may cause or exacerbate, mental *and* somatic disorders.

Bereavement is an important and well-established risk factor for depression. At least 10 to 20 percent of widows and widowers develop clinically significant depression during the first year of bereavement. Without treatment, such depressions tend to persist, become chronic, and lead to further disability and impairments in general health, including alterations in endocrine and immune function (*Zisook & Shuchter, Zisook et al.*). Several preventive interventions, including participation in self-help groups, have

been shown to prevent depression among widows and widowers, although one study suggested that self-help groups can exacerbate depressive symptoms in certain individuals (*Levy et al.*).

Bereavement-associated depression often coexists with another type of emotional distress, which has been termed traumatic grief (*Prigerson et al., in press*). The symptoms of traumatic grief appear to be a mixture of symptoms of both pathological grief and posttraumatic stress disorder (*Frank et al.*). Such symptoms are extremely disabling, associated with functional and health impairment and with persistent suicidal thoughts, and may well respond to pharmacotherapy (*Zygmont et al.*). Increased illness and mortality from suicide are the most serious consequences of late-life depression. The dynamics around loss in later life need greater clarification. One pivotal question is why some, in confronting loss with aging, succumb to depression and suicide—which, as noted earlier, has its highest frequency after age 65—while others respond with new adaptive strategies. Research on health promotion also needs to identify ways to prevent adverse reactions and to promote positive responses to loss in later life. Meanwhile, despite cultural attitudes that older persons can handle bereavement by themselves or with support from family and friends, it is imperative that those who are unable to cope be encouraged to access mental health services. Bereavement is not a mental disorder but, if unattended to, has serious mental health and other health consequences.

Disorders

Older adults are encumbered by many of the same mental disorders as are other adults; however, the prevalence, nature, and course of each disorder may be very different. This section provides a general overview of assessment, diagnosis, and treatment of mental disorders in older people. Its purpose is to describe issues common to many mental disorders.

Assessment and diagnosis of late-life mental disorders are especially challenging by virtue of several distinctive characteristics of older adults. First, the clinical presentation of older adults with mental disorders may be different from that of other adults, making detection of treatable illness more difficult. For example, many older individuals present with somatic complaints and experience symptoms of depression and anxiety that do not meet the full criteria for depressive or anxiety disorders. The consequences of these sub-syndromal conditions may be just as deleterious as

the syndromes themselves. Failure to detect individuals who truly have treatable mental disorders represents a serious public health problem (*National Institutes of Health [NIH] Consensus Development Panel on Depression in Late Life*).

Detection of mental disorders in older adults is complicated further by high comorbidity with other medical disorders. The symptoms of somatic disorders may mimic or mask psychopathology, making diagnosis more taxing. In addition, older individuals are more likely to report somatic symptoms than psychological ones, leading to further under identification of mental disorders (*Blazer*). Primary care providers carry much of the burden for diagnosis of mental disorders in older adults, and, unfortunately, the rates at which they recognize and properly identify disorders often are low. With respect to depression, for example, a significant number of depressed older adults are neither diagnosed nor treated in primary care (*NIH Consensus Development Panel on Depression in Late Life, Unutzer et al.*). In one study of primary care physicians, only 55 percent of internists felt confident in diagnosing depression, and even fewer (*35 percent of the total*) felt confident in prescribing antidepressants to older persons (*Callahan et al.*). Physicians were *least* likely to report that they felt "very confident" in evaluating depression in other late-life conditions (*Gallo et al., in press*). Researchers estimate that an *unmet* need for mental health services may be experienced by up to 63 percent of adults aged 65 years and older with a mental disorder, based on prevalence estimates from the Epidemiologic Catchment Area (ECA) study (*Rabins*).

The large unmet need for treatment of mental disorders reflects *patient* barriers (e.g., preference for primary care, tendency to emphasize somatic problems, reluctance to disclose psychological symptoms), *provider* barriers (e.g., lack of awareness of the manifestations of mental disorders, complexity of treatment, and reluctance to inform patients of a diagnosis), and mental health delivery *system* barriers (e.g., time pressures, reimbursement policies).

Stereotypes about normal aging also can make diagnosis and assessment of mental disorders in late life challenging. For example, many people believe that "senility" is normal and therefore may delay seeking care for relatives with dementing illnesses. Similarly, patients and their families may believe that depression and hopelessness are natural conditions of older age,

especially with prolonged bereavement. Cognitive decline, both normal and pathological, can be a barrier to effective identification and assessment of mental illness in late life. Obtaining an accurate history, which may need to be taken from family members, is important for diagnosis of most disorders and especially for distinguishing between somatic and mental disorders. Normal decline in short-term memory and especially the severe impairments in memory seen in dementing illnesses hamper attempts to obtain good patient histories. Similarly, cognitive deficits are prominent features of many disorders of late life that make diagnosis of psychiatric disorders more difficult.

Prevention in mental health has been seen until recently as an area limited to childhood and adolescence. Now there is mounting awareness of the value of prevention in the older population. While the body of published literature is not as extensive as that for diagnosis or treatment, investigators are beginning to shape new approaches to prevention. Yet because prevention research is driven, in part, by refined understanding of disease etiology—and etiology research itself continues to be rife with uncertainty—prevention advances are expected to lag behind those in etiology.

There are many ways in which prevention models can be applied to older individuals, provided a broad view of prevention is used (*Lebowitz & Pearson, in press*). Such a broad view entails interventions for reducing the risk of developing, exacerbating, or experiencing the consequences of a mental disorder. Consequently, this section covers primary prevention (including the prevention of depression and suicide), treatment-related prevention, prevention of excess disability, and prevention of premature institutionalization. However, many of the research advances noted in this section have yet to be translated into practice. Given the frequency of memory complaints and depression, the time may soon arrive for older adults to be encouraged to have "mood and memory checkups" in the same manner that they are now encouraged to have physical checkups (N. Abeles, personal communication).

Primary prevention, the prevention of disease before it occurs, can be applied to late-onset disorders. Progress in our understanding of etiology, risk factors, pathogenesis, and the course of mental disorders stimulates and channels the development of prevention interventions. The largest body of primary prevention research focuses on late-life depression, where some

progress has been documented. With other disorders, primary prevention research is in its infancy. Prevention in Alzheimer's disease might target individuals at increased genetic risk with prophylactic nutritional (e.g., vitamin E), cholinergic, or amyloid-targeting interventions. Prevention research on late-onset schizophrenia might explore potential protective factors, such as estrogen.

Depression is strikingly prevalent among older people. As noted below, at least 8 to 20 percent of older adults in the community and up to 37 percent in primary care settings experience symptoms of depression.
One approach to preventing depression is through grief counseling for widows and widowers. For example, participation in self-help groups appears to ameliorate depression, improve social adjustment, and reduce the use of alcohol and other drugs of abuse in widows (*Constantino, Lieberman & Videka-Sherman*). The efficacy of self-help groups approximates that of brief psychodynamic psychotherapy in older bereaved individuals without significant prior psychopathology (*Marmar et al.*). The battery of psychosocial and pharmacological treatments to prevent *recurrences* of depression (i.e., secondary prevention) is discussed later in this chapter under the section on depression. Depression is a foremost risk factor for suicide in older adults (*Conwell, Conwell et al.*). Older people have the highest rates of suicide in the U.S. population: suicide rates increase with age, with older white men having a rate of suicide up to six times that of the general population (*Kachur et al., Hoyert et al.*). Despite the prevalence of depression and the risk it confers for suicide, depression is neither well recognized nor treated in primary care settings, where most older adults seek and receive health care (*Unutzer et al.*). Studies described in the depression section of this chapter have found that undiagnosed and untreated depression in the primary care setting plays a significant role in suicide (*Caine et al.*). This awareness has prompted the development of suicide prevention strategies expressly for primary care. One of the first published suicide prevention studies, an uncontrolled experiment conducted in Sweden, suggested that a depression training program for general practitioners reduces suicide (*Rihmer et al.*). Suicide interventions, especially in the primary care setting, have become a priority of the U.S. Public Health Service, with lead responsibility assumed by the Office of the Surgeon General and the National Institute of Mental Health. Depression and suicide prevention strategies also are important for nursing home residents. About half of patients newly relocated to nursing homes are at heightened risk for depression (*Parmelee et al.*).

Prevention of relapse or recurrence of the underlying mental disorder is important for improving the mental health of older patients with mental disorders. For example, treatments that are applied with adequate intensities for depression (*Schneider*) and for depression in Alzheimer's disease (*Small et al.*) may prevent relapse or recurrence. Substantial residual disability in chronically mentally ill individuals (*Lebowitz et al.*) suggests that treatment must be approached from a longer term perspective (*Reynolds et al.*). Prevention of medication side effects and adverse reactions also is an important goal of treatment-related prevention efforts in older adults. Comorbidity and the associated polypharmacy for multiple conditions are characteristic of older patients. New information on the genetic basis of drug metabolism and on the action of drug-metabolizing enzymes can lead to a better understanding of complex drug interactions (*Nemeroff et al.*). For example, many of the selective serotonin reuptake inhibitors compete for the same metabolic pathway used by beta-blockers, type 1C antiarrhythmics, and benzodiazepines (*Nemeroff et al.*). This knowledge can assist the clinician in choosing medications that can prevent the likelihood of side effects. In addition, many older patients require antipsychotic treatment for management of behavioral symptoms in Alzheimer's disease, schizophrenia, and depression. Although doses tend to be quite low, age and length of treatment represent major risk factors for movement disorders (*Saltz et al., Jeste et al.*). Recent research on older people suggests that the newer antipsychotics present a much lower risk of movement disorders, highlighting their importance for prevention (*Jeste et al., in press*). Finally, body sway and postural stability are affected by many drugs, although there is wide variability within classes of drugs (*Laghrissi-Thode et al.*). Minimizing the risk of falling, therefore, is another target for prevention research. Falls represent a leading cause of injury deaths among older persons (IOM).

Prevention efforts in older mentally ill populations also target avoidance of excessive disability. The concept of excess disability refers to the observation that many older patients, particularly those with Alzheimer's disease and other severe and persistent mental disorders, are more functionally impaired than would be expected according to the stage or severity of their disorder. Medical, psychosocial, and environmental factors all contribute to excess disability. For example, depression contributes to excess disability by hastening functional impairment in patients with Alzheimer's disease (*Ritchie et al.*). The fast pace of modern life, with its

emphasis on independence, also contributes to excess disability by making it more difficult for older adults with impairments to function autonomously. Attention to depression, anxiety, and other mental disorders may reduce the functional limitations associated with concomitant mental and somatic impairments. Many studies have demonstrated that attention to these factors and aggressive intervention, where appropriate, maximize function (*Lebowitz & Pearson, in press*).

Another important goal of prevention efforts in older adults is prevention of premature institutionalization. While institutional care is needed for many older patients who suffer from severe and persistent mental disorders, delay of institutional placement until absolutely necessary generally is what patients and family caregivers prefer. It also has significant public health impact in terms of reducing costs. A randomized study of counseling and support versus usual care for family caregivers of patients with Alzheimer's disease found the intervention to have delayed patients' nursing home admission by over 300 days (*Mittelman et al.*). The intervention also resulted in a significant reduction in depressive symptoms in the caregivers. The intervention consisted of three elements: individual and family counseling sessions, support group participation, and availability of counselors to assist with patient crises. The growing importance of avoiding premature institutionalization is illustrated by its use as one measure of the effectiveness of pharmacotherapy in older individuals. For example, clinical trials of drugs for Alzheimer's disease have begun using delay of institutionalization as a primary outcome (*Sano et al.*) or as a longer-term outcome in a follow-up study after the double-blind portion of the clinical trial ended (*Knopman et al.*).

Treatment of mental disorders in older adults encompasses pharmacological interventions and psychosocial interventions. While the pharmacological and psychosocial interventions used to treat mental health problems and specific disorders may be identical for older and younger adults, characteristics unique to older adults may be important considerations in treatment selection. The special considerations in selecting appropriate medications for older people include physiological changes due to aging; increased vulnerability to side effects, such as tardive dyskinesia; the impact of polypharmacy; interactions with other comorbid disorders; and barriers to compliance. All are discussed below.

The aging process leads to numerous changes in physiology, resulting in altered blood levels of certain medications, prolonged pharmacological effects, and greater risk for many side effects (*Kendell et al.*). Changes may occur in the absorption, distribution, metabolism, and excretion of psychotropic medications (*Pollock & Mulsant*). As people age, there is a gradual decrease in gastrointestinal motility, gastric blood flow, and gastric acid production (*Greenblatt et al.*). This slows the *rate* of absorption, but the overall *extent* of gastric absorption is probably comparable to that in other adults. The aging process is also associated with a decrease in total body water, a decrease in muscle mass, and an increase in adipose tissue (*Borkan et al.*). Drugs that are highly lipophilic, such as neuroleptics, are therefore more likely to be accumulated in fatty tissues in older patients than they are in younger patients.

The liver undergoes changes in blood flow and volume with age. Phase I metabolism (oxidation, reduction, hydrolysis) may diminish or remain unchanged, while phase II metabolism (conjugation with an endogenous substrate) does not change with aging. Renal blood flow, glomerular surface area, tubular function, and reabsorption mechanisms all have been shown to diminish with age. Diminished renal excretion may lead to a prolonged half-life and the necessity for a lower dose or longer dosing intervals. Pharmacodynamics, which refers to the drug's effect on its target organ, also can be altered in older individuals. An example of aging-associated pharmacodynamic change is diminished central cholinergic function contributing to increased sensitivity to the anticholinergic effects of many neuroleptics and antidepressants in older adults (*Molchan et al.).*
Because of the pharmacokinetic and pharmacodynamic concerns presented above, it is often recommended that clinicians "start low and go slow" when prescribing new psychoactive medications for older adults. In other words, efficacy is greatest and side effects are minimized when initial doses are small and the rate of increase is slow. Nevertheless, the medication should generally be titrated to the regular adult dose in order to obtain the full benefit. The potential pitfall is that, because of slower titration and the concomitant need for more frequent medical visits, there is less likelihood of older adults receiving an adequate dose and course of medication.

Older people encounter an increased risk of side effects, most likely the result of taking multiple drugs or having higher blood levels of a given drug. The increased risk of side effects is especially true for neuroleptic agents,

which are widely prescribed as treatment for psychotic symptoms, agitation, and behavioral symptoms. Neuroleptic side effects include sedation, anticholinergic toxicity (which can result in urinary retention, constipation, dry mouth, glaucoma, and confusion), extrapyramidal symptoms (e.g., parkinsonism, akathisia, and dystonia), and tardive dyskinesia. Tardive dyskinesia is a frequent and persistent side effect that occurs months to years after initiation of neuroleptics. In older adults, tardive dyskinesia typically entails abnormal movements of the tongue, lips, and face. In a recent study of older outpatients treated with conventional neuroleptics the incidence of tardive dyskinesia after 12 months of neuroleptic treatment was 29 percent of the patients. At 24 and 36 months, the mean cumulative incidence was 50.1 percent and 63.1 percent, respectively (*Jeste et al.*). This study demonstrates the high risk of tardive dyskinesia in older patients even with low doses of conventional neuroleptics. Studies of younger adult patients reveal an annual cumulative incidence of tardive dyskinesia at 4 to 5 percent (*Kane et al.*).

Unlike conventional neuroleptics, the newer atypical ones, such as clozapine, risperidone, olanzapine, and quetiapine, apparently confer several advantages with respect to both efficacy and safety. These drugs are associated with a lower incidence of extrapyramidal symptoms than conventional neuroleptics are. For clozapine, the low risk of tardive dyskinesia is well established (*Kane et al.*). The incidence of tardive dyskinesia with other atypical antipsychotics is also likely to be lower than that with conventional neuroleptics because extrapyramidal symptoms have been found to be a risk factor for tardive dyskinesia in older adults (*Saltz et al., Jeste et al.*). The determination of exact risk of tardive dyskinesia with these newer drugs needs long-term studies.

In addition to the effects of aging on pharmacokinetics and pharmacodynamics and the increased risk of side effects, older individuals with mental disorders also are more likely than other adults to be medicated with multiple compounds, both prescription and nonprescription (i.e., polypharmacy). Older adults (over the age of 65) fill an average of 13 prescriptions a year (for original or refill prescriptions), which is approximately three times the number filled by younger individuals (*Chrischilles et al.*). Polypharmacy greatly complicates effective treatment of mental disorders in older adults. Specifically, drug-drug interactions are of concern, both in terms of increasing side effects and decreasing efficacy of one or both compounds.

Compliance with the treatment regimen also is a special concern in older adults, especially in those with moderate or severe cognitive deficits. Physical problems, such as impaired vision, make it likely that instructions may be misread or that one medicine may be mistaken for another. Cognitive impairment may also make it difficult for patients to remember whether or not they have taken their medication. Although in general, older patients are more compliant about taking psychoactive medications than other types of drugs (*Cooper et al.*), when noncompliance does occur, it may be less easily detected, more serious, less easily resolved, mistaken for symptoms of a new disease, or even falsely labeled as "old-age" symptomatology. Accordingly, greater emphasis must be placed on strict compliance by patients in this age group (*Lamy et al.).* Medication noncompliance takes different forms in older adults, that is, overuse and abuse, forgetting, and alteration of schedules and doses. The most common type of deliberate noncompliance among older adults may be the underuse of the prescribed drug, mainly because of side effects and cost considerations. Factors that contribute to medication noncompliance in older patients include inadequate information given to them regarding the necessity for drug treatment, unclear prescribing directions, suboptimal doctor-patient relationship, the large number of times per day drugs must be taken, and the large number of drugs that are taken at the same time (Lamy et al.). Better compliance may be achieved by giving simple instructions and by asking specific questions to make sure that the patient understands directions.

Several types of psychosocial interventions have proven effective in older patients with mental disorders, but the research is more limited than that on pharmacological interventions (*see Klausner & Alexopoulos, in press*). Both types are frequently used in combination. Most of the research has been restricted to psychosocial treatments for depression, although, as discussed below, there is mounting interest in dementia. For other mental disorders, psychosocial interventions found successful for younger adults are often tailored to older people in the practice setting without the benefit of efficacy research. Despite the relative paucity of research, psychosocial interventions may be preferred for some older patients, especially those who are unable to tolerate, or prefer not to take, medication or who are confronting stressful situations or low degrees of social support (*Lebowitz et al.*). The benefits of psychosocial interventions are likely to assume greater prominence as a result of population demographics: as the number of older people grows,

progressively more older people in need of mental health treatment—
especially the very old—are expected to be suffering from greater levels of
comorbidity or dealing with the stresses associated with disability.
Psychosocial interventions not only can help relieve the symptoms of a
variety of mental disorders and related problems but also can play more
diverse roles: they can help strengthen coping mechanisms, encourage (and
monitor) patients' compliance with medications, and promote healthy
behavior (*Klausner & Alexopoulos, in press*).

New approaches to service delivery are being designed to realize the benefits
of established psychosocial interventions. Many older people are not
comfortable with traditional mental health settings, partially as a result of
stigma (*Waters*). In fact, many older people *prefer* to receive treatment for
mental disorders by their primary care physicians, and most older people *do*
receive such care in the primary care setting (*Brody et al., Unutzer et al.*).
Since older people show willingness to accept psychosocial interventions in
the primary care setting, new models are striving to integrate into the
primary care setting the delivery of specialty mental health services. The
section of this chapter on service delivery discusses new models in greater
detail.

A problem common to both pharmacological and psychosocial interventions
is the disparity between treatment efficacy, as demonstrated in randomized
controlled clinical trials, and effectiveness in real-world settings. While this
problem is certainly not unique to older people, this problem is especially
significant for older people with mental disorders. Older people are
often under-treated for their mental disorders in primary care settings
(Unutzer et al.). When they do receive appropriate treatment, older people
are more likely than other people to have co-morbid disorders and social
problems that reduce treatment effectiveness (*Unutzer et al.*). An additional
overlay of barriers, including financing and systems of care, is discussed
later in this chapter.

Other Mental Disorders in Older Adults

Anxiety Disorders

Anxiety symptoms and syndromes are important but understudied conditions
in older adults. Overall, community-based prevalence estimates indicate that

about 11.4 percent of adults aged 55 years and older meet criteria for an anxiety disorder in 1 year (Flint). Phobic anxiety disorders are among the most common mental disturbances in late life according to the ECA study. Prevalence studies of panic disorder (0.5 percent) and obsessive-compulsive disorder (1.5 percent) in older samples reveal low rates (*Copeland et al., Copeland et al., Bland et al., Lindesay et al.*). Although the National Comorbidity Survey did not cover this age range, and the ECA did not include this disorder, other studies showed a prevalence of generalized anxiety disorder in older adults ranging from 1.1 percent to 17.3 percent higher than that reported for panic disorder or obsessive-compulsive disorder (*Copeland et al., Skoog*). Worry or "nervous tension," rather than specific anxiety syndromes may be more important in older people. Anxiety symptoms that do not fulfill the criteria for specific syndromes are reported in up to 17 percent of older men and 21 percent of older women (*Himmelfarb & Murrell*). In addition, some disorders that have received less study in older adults may become more important in the near future. For example, post-traumatic stress disorder (PTSD) is expected to assume increasing importance as Vietnam veterans age. At 19 years after combat exposure, this cohort of veterans has been found to have a PTSD prevalence of 15 percent (*cited in McFarlane & Yehuda*). As affected patients age, there is a continuing need for services. In addition, research has shown that PTSD can manifest for the first time long after the traumatic event (*Aarts & Op den Velde*), raising the specter that even more patients will be identified in the future.

The effectiveness of benzodiazepines in reducing *acute* anxiety has been demonstrated in younger and older patients, and no differences in the effectiveness have been documented among the various benzodiazepines. Some research suggests that benzodiazepines are marginally effective at best in treating *chronic* anxiety in older patients (*Smith et al.*). The half-life of certain benzodiazepines and their metabolites may be significantly extended in older patients (particularly for the compounds with long half-life). If taken over extended periods, even short-acting benzodiazepines tend to accumulate in older individuals. Thus, it is generally recommended that any use of benzodiazepines be limited to discrete periods (less than 6 months) and that long-acting compounds be avoided in this population. On the other hand, use of short-acting compounds may predispose older patients to withdrawal symptoms (*Salzman*). Side effects of benzodiazepines may include drowsiness, fatigue, psychomotor impairment, memory or other cognitive impairment, confusion, paradoxical reactions, depression,

respiratory problems, abuse or dependence problems, and withdrawal reactions. Benzodiazepine toxicity in older patients includes sedation, cerebellar impairment (manifested by ataxia, dysarthria, incoordination, or unsteadiness), cognitive impairment, and psychomotor impairment (*Salzman*). Psychomotor impairment from benzodiazepines can have severe consequences, leading to impaired driver skills and motor vehicle crashes (*Barbone et al.*) and falls (*Caramel et al.*). Buspirone is an anxiolytic (antianxiety) agent that is chemically and pharmacologically distinct from benzodiazepines. Controlled studies with younger patients suggest that the efficacy of buspirone is comparable to that of the benzodiazepines. It also has proven effective in studies of older patients. On the other hand, buspirone may require up to 4 weeks to take effect, so initial augmentation with another antianxiety medication may be necessary for some acutely anxious patients (*Sheikh*). Significant adverse reactions to buspirone are found in 20 to 30 percent of anxious older patients (Napoliello, Robinson et al.). The most frequent side effects include gastrointestinal symptoms, dizziness, headache, sleep disturbance, nausea/vomiting, uneasiness, fatigue, and diarrhea. Still, buspirone may be less sedating than benzodiazepines (*Salzman, Seidel et al.*). Although the efficacy of antidepressants for the treatment of anxiety disorders in late life has not been studied, current patterns of practice are informed by the efficacy literature in adults in midlife.

Although schizophrenia is commonly thought of as an illness of young adulthood, it can both extend into and first appear in later life. Diagnostic criteria for schizophrenia are the same across the life span. Symptoms include delusions, hallucinations, disorganized speech, disorganized or catatonic behavior (the so-called "positive" symptoms), as well as affective flattening, alogia, or avolition (the so-called "negative" symptoms). Symptoms must cause significant social or occupational dysfunction, must not be accompanied by prominent mood symptoms, and must not be uniquely associated with substance use.

One-year prevalence of schizophrenia among those 65 years or older is reportedly only around 0.6 percent, about one-half the 1-year prevalence of the 1.3 percent that is estimated for the population aged 18 to 54. The economic burden of late-life schizophrenia is high. A study using records from a large California county found the mean cost of mental health service for schizophrenia to be significantly higher than that for other mental disorders (*Cuffel et al.*); the mean expenditure among the oldest patients

with schizophrenia (> 74 years old) was comparable to that among the youngest patients (age 18 to 29). While long-term studies have shown that use of nursing homes, state hospitals, and general hospital care by patients with all mental disorder diagnoses has declined in recent decades, the rate of decline is lower for older patients with schizophrenia (*Kramer et al., Redick et al.*). The high cost of these settings contributes to the greater economic burden associated with late-life schizophrenia.

Studies have compared patients with late onset (age at onset 45 years or older) and similarly aged patients with earlier onset of schizophrenia (*Jeste et al.*) both were very similar in terms of genetic risk, clinical presentation, treatment response, and course. Among key differences between the groups, patients with late-onset schizophrenia were more likely to be women in whom paranoia was a predominant feature of the illness. Patients with late-onset schizophrenia had less impairment in the specific neurocognitive areas of learning and abstraction/ cognitive flexibility and required lower doses of neuroleptic medications for management of their psychotic symptoms. These and other differences between patients with early- and late-onset illness suggest that there might be neurobiologic differences mediating the onset of symptoms (*DeLisi, Jeste et al., in press*).

The original conception of "dementia praecox," the early term for schizophrenia, emphasized progressive decline (*Kraepelin*); however, it now appears that Kraepelin's picture captures the outcome for a small percentage of patients, while one-half to two-thirds significantly improve or recover with treatment and psychosocial rehabilitation. Although the rates of full remission remain unclear, some patients with schizophrenia demonstrate remarkable recovery after many years of chronic dysfunction (*Nasar)*. Research suggests that a factor in better long-term outcome is early intervention with antipsychotic medications during a patient's first psychotic episode.

A cross-sectional study that compared middle-aged with older patients, all of whom lived in community settings, found some similarities and differences (*Eyler-Zorrilla et al.*). The older patients experienced less severe symptoms overall and were on lower daily doses of neuroleptics than middle middleaged patients who were similar in demographic, clinical, functional, and broad cognitive measures. In addition, positive symptoms were less prominent (or equivalent) in the older group, depending on the

measure used. Negative symptoms were more prominent (or equivalent) in the older group, and older patients scored more poorly on severity of dyskinesia. Older patients were impaired relative to middle-aged ones on two measures of global cognitive function. This finding, however, appeared to reflect a normal degree of decline from an impaired baseline, as the degree of change in cognitive function with age in the patient group was equivalent to that seen in the comparison group. A recent study used the Direct Assessment of Functional Status scale (DAFS) (*Loewenstein et al.*) to compare the everyday living skills of middle-aged and older adults with schizophrenia with those of people without schizophrenia of similar ages *(Klapow et al.)*. The patients exhibited significantly more functional limitations than the controls did across most DAFS sub-scales. In another recent study that used a measure of overall disease impact, the Quality of Well-Being Scale, older outpatients with schizophrenia manifested significantly lower quality of well-being than did comparison subjects, and their scores were slightly worse than those of ambulatory AIDS patients (*Patterson et al.*). Thus, while schizophrenia may be less universally deteriorating than previously has been assumed, older patients with the disorder continue nonetheless to exhibit functional deficits that warrant research and clinical attention.

Recent studies support a neurodevelopmental view of late-onset schizophrenia (*Jeste et al.*). Equivalent degrees of childhood maladjustment have been found in patients with late-onset schizophrenia and early onset schizophrenia, for example, suggesting that some liability for the disorder exists early in life. Equivalent degrees of minor physical anomalies in patients with late-onset schizophrenia and early-onset schizophrenia suggest the presence of developmental defects in both groups (*Lohr et al.*). The presence of a genetic contribution to late-onset and early-onset schizophrenia is evident in increased rates of schizophrenia among first-degree relatives (*Rokhlina, Castle & Howard, Castle et al.*).

If late-onset schizophrenia is neurodevelopmental in origin, an explanation for the delayed onset may be that late-onset schizophrenia is a less severe form of the disorder and, as such, is less likely to manifest early in life. Recent research suggests that in several arenas— for example, neuropsychological impairments in learning, retrieval, abstraction, and semantic memory as well as electroencephalogram abnormalities—the

deficits of patients with late-onset schizophrenia are less severe (*Heaton et al., Jeste et al., Olichney et al., Paulsen et al.*). Also, negative symptoms are less pronounced and neuroleptic doses are lower in patients with late-onset schizophrenia (*Jeste et al.*). The etiology and onset of schizophrenia in younger adults often are explained by a diathesis-stress model in which there is a genetic vulnerability in combination with an environmental insult (such as obstetric complications), with onset triggered by maturational changes or life events that stress a developmentally damaged brain (*Feinberg, Weinberger, Wyatt)*. Under this multiple insult model, patients with late onset schizophrenia may have had fewer insults and thus have a delayed onset. An alternative or complementary explanation for the delayed onset in late-onset schizophrenia is the possibility that these patients possess protective features that cushion the blow of any additional insults. The preponderance of women among patients with late-onset schizophrenia has fueled hypotheses that estrogen plays a protective role. The view of late-onset schizophrenia as a less severe form of schizophrenia, in which the delayed onset results from fewer detrimental insults or the presence of protective factors, suggests a continuous relationship between age at onset and severity of liability. An alternative view is that late-onset schizophrenia is a distinct neurobiological subtype of schizophrenia. The preponderance of women and of paranoid subtype patients seen in late-onset schizophrenia supports this view. These two etiologic theories of late-onset schizophrenia call for further research.

Pharmacological treatment of schizophrenia in late life presents some unique challenges. Conventional neuroleptic agents, such as haloperidol, have proven effective in managing the "positive symptoms" (such as delusions and hallucinations) of many older patients, but these medications have a high risk of potentially disabling and persistent side effects, such as tardive dyskinesia (*Jeste et al., in press*). The cumulative annual incidence of tardive dyskinesia among older outpatients (29 percent) treated with relatively low daily doses of conventional antipsychotic medications is higher than that reported in younger adults (*Jeste et al., in press*). Recent years have witnessed promising advances in the management of schizophrenia. Studies with mostly younger schizophrenia patients suggest that the newer "atypical" antipsychotics, such as clozapine, risperidone, olanzapine, and quetiapine, may be effective in treating those patients previously unresponsive to traditional neuroleptics. They also are associated with a lower risk of extrapyramidal symptoms and tardive dyskinesia (*Jeste et al., in press*). Moreover, the newer medications may be

more effective in treating negative symptoms and may even yield partial improvement in certain neurocognitive deficits associated with this disorder (*Green et al.*). The foremost barriers to the widespread use of atypical antipsychotic medications in older adults are (1) the lack of large-scale studies to demonstrate the effectiveness and safety of these medications in older patients with multiple medical conditions, and (2) the higher cost of these medications relative to traditional neuroleptics (Thomas & Lewis).

Older adults with severe and persistent mental disorders (SPMD) are the most frequent users of long term care either in community or institutional settings. SPMD in older adults includes lifelong and late-onset schizophrenia, delusional disorder, bipolar disorder, and recurrent major depression. It also includes Alzheimer's disease and other dementias (and related behavioral symptoms, including psychosis), severe treatment-refractory depression, or severe behavioral problems requiring intensive and prolonged psychiatric

4. Older Adults Living with Serious Mental Illness

Population projections show that Americans are living longer and that women outlive men. The population of adults that are 65 years old and over is becoming more diverse. Of the 49.2 million adults over the age of 65 years, 1.4 to 4.8 percent suffer from serious mental illnesses (SMIs).

The needs and growth of the older population with SMI exceeds the number of behavioral health providers that are trained in geriatric care. Further, the workforce that works most frequently with geriatric populations (primary care physicians, assisted living and nursing home staff, emergency department staff, inpatient hospital staff, and family members) are not routinely trained in how to recognize or effectively address SMIs.

Geriatric mental health workforce refers to the range of personnel providing services to older adults with mental health conditions. The terms "older adult" and "geriatric population" refer to individuals age 65 and older. As a normal course of aging, older adults experience changes to their physical health, mental health, and cognitions. Interactions among these age-related factors can result in "spiral" or "cascade" of decline in physical, cognitive, and psychological health. A report of the National Association of State

Mental Health Program Directors indicates that people with SMI die earlier than the general population and are at higher risk for multiple adverse health outcomes. There may be a number of reasons. Older adults with an SMI have substantially higher rates of diabetes, lung disease, cardiovascular disease, and other co-morbidities that are associated with early mortality, disability, and poor function. They also have significant impairments in psychosocial functioning. Older adults with SMI account for disproportionately high costs and service use. Lifestyle and behaviors (e.g., tobacco and alcohol use, sedentary) may put older adults with SMI at greater risk for metabolic side effects of antipsychotic medications and lead to obesity and chronic physical health conditions.

Among older adults, the rate of substance use disorders is reported as .2 to 1.9 percent. Approximately 1.4 percent of older women and 2.2 percent of older men reported past-year use of illicit drugs, including marijuana, cocaine, heroin, and prescription psychotherapeutic medications, such as pain relievers and anti-anxiety medications that are used for nonmed-ical purposes. The National Survey of Drug Use and Health data indicate that there are approximately 863,000 older adults with a substance use disorder involving illicit drugs or alcohol, but only 240,000 (approximately 27 percent) received treatment for their substance use problem. 59 Prevalence rates for older-adult at-risk drinking (defined as more than 3 drinks per occasion; more than 7 drinks per week) are estimated to be 16.0 percent for men and 10.9 percent for women. For individuals who are 50 years old and up, misuse of opioids is projected to be 2 percent.

The most recent data suggests that more than 7,000 people age 65 or older died by suicide. Suicide rates are particularly high among older men, although suicide attempts are more common among older women. Suicide attempts are more likely to result in death among older adults than among younger people.

The Changing Demographic of the Aging Population

Approximately 20 percent of adults that are 65 years old and over will experience mental health issues, up to 4.8 percent will have an SMI. There are a number of challenges to meeting the needs of older adults with SMI. For example, there is little guidance on what core knowledge is key for a workforce to address the needs of older adults with SMI, or how much training is needed. The diversity of the population in terms of ethnicity,

culture, and language make it a challenge to identify core capabilities of a workforce. Thus, there are significant gaps in the behavioral health care accessible and provided to non-white populations.

A big challenge for the workforce is the need to balance the principles of respecting the autonomy of the older adult with SMI and promoting their welfare, since sometimes a client's decisionmaking capacity is in question. Interestingly, some have even argued that the workforce should look at the needs of older adults as a dichotomy, with the young old (age 60-74) and the older old (age 75 and up). This is because many more individuals in the older old group live alone, are less mobile, and have increased numbers of physical health problems that need to be addressed.

Older adults are at least 40 percent less likely than younger individuals to seek or receive treatment for mental health conditions. Those who seek services are unlikely to be seen by a provider who is trained in how to address the needs of a geriatric population.

There are a number of clinical situations when working with older adults with SMI that may require additional knowledge and training of both the general and specialty workforce. Agitation can be common among older adults when there are co-occurring dementias and medical conditions, even in the absence of SMI. Agitation also can be prevented or reduced by utilizing behavioral cues and supports such as orienting signs, proper lighting, and having familiar caregivers. Training guides for direct care staff, which provide practical behavioral interventions for people with dementia, are available. Personal contact with a known individual can be helpful in preventing episodes of agitation. Such behavioral interventions require a trained, consistent, and proficient work-force.

A number of guidelines exist to help inform behavioral and therapeutic interventions. Unfortunately, however, workforce shortages contribute to challenges with the implementation of behavioral interventions and other supports. When an individual's behavior becomes concerning in a community or residential setting, consultation with geriatric psychiatrists and other specialists can be helpful in directing care. Such specialists can make recommendations to rule out physical and neurologic conditions which may be contributing to the behaviors, such as stroke, infection, or other physical causes, and will make additional recommendations about behavioral and/or pharmacologic interventions. In addition, specialists can be helping in ongoing management. For older adults with serious mental

illnesses such as schizophrenia, ongoing treatment antipsychotics may be recommended. Consultation and/or ongoing treatment with a specialist may be helpful in individuals with multiple medical and psychiatric conditions. If the safety of the individual or others is at stake, medications can be used to manage behaviors, in addition to behavioral health interventions. A poorly trained or inadequate work-force – such as the unavailability of specialists, or low staff ratios to help provide behavioral supports - may contribute to the over-reliance on medications, such as antipsychotics, to manage agitation. In some circumstances, antipsychotics may be over-utilized in community and residential settings. A black box warning was implemented by the Federal Drug Administration for antipsychotic use among older adults in nursing home settings due concerns about increased mortality. Subsequent actions by the Office of the Inspector General and the Government Accountability Office highlight-ed the elevated use of antipsychotics in both community and nursing home settings.

For older adults with serious mental illness, there is even more need for well-trained caregivers, primary providers, and specialists. Having an adequate workforce will result in better care as well as decreased reliance on medications that may have the potential to cause adverse effects.

Coping with Aging and Depression: Treatment Considerations

Coping and Well-being

Many variables impact coping and well being in the elderly. Social support, religion and spirituality, active engagement with life and having an internal locus of control have been proposed as being beneficial in helping elderly people to cope with stressful life events. Social support and personal control are possibly the two most important factors that predict well-being, morbidity and mortality in adults. Other factors that may link to well-being and quality of life in the elderly include social relationships (possibly relationships with pets as well as humans), and health *(Fentleman, D.L., Smith, J. & Peterson, J, Successful aging in a postretirement society. In P.B. Baltes and M.M. Baltes Eds. Successful aging: Perspectives from the Behavioral Sciences).*

Individuals in different wings in the same retirement home have demonstrated a lower risk of mortality and higher alertness and self-rated

health in the wing where residents had greater control over their environment, though personal control may have less impact on specific measures of health. Social control, perceptions of how much influence one has over one's social relationships, shows support as a moderator variable for the relationship between social support and perceived health in the elderly, and may positively influence coping in the elderly *(Fentleman, D.L., Smith, J. & Peterson, J., Successful aging in a postretirement society. In P.B. Baltes and M.M. Baltes Eds. Successful aging: Perspectives from the Behavioral Sciences).*

Religion

Religion has been an important factor used by the elderly in coping with the demands of later life, and appears more often than other forms of coping later in life. Religious commitment may also be associated with reduced mortality, though religiosity is a multidimensional variable; while participation in religious activities in the sense of participation in formal and organized rituals may decline, it may become a more informal, but still important aspect of life such as through personal or private prayer *(Fentleman, D.L., Smith, J. & Peterson, J., Successful aging in a postretirement society. In P.B. Baltes and M.M. Baltes Eds. Successful aging: Perspectives from the Behavioral Sciences).*

Self-Rated Health

Self-ratings of health, the beliefs in one's own health as excellent, fair or poor, has been correlated with well-being and mortality in the elderly; positive ratings are linked to high well-being and reduced mortality. Various reasons have been proposed for this association; people who are objectively healthy may naturally rate their health better than that of their ill counterparts, though this link has been observed even in studies which have controlled for socioeconomic status, psychological functioning and health status. This finding is generally stronger for men than women, though the pattern between genders is not universal across all studies, and some results suggest sex-based differences only appear in certain age groups, for certain causes of mortality and within a specific sub-set of self-ratings of health *(Fentleman, D.L., Smith, J. & Peterson, J., Successful aging in a postretirement society. In P.B. Baltes and M.M. Baltes Eds. Successful aging: Perspectives from the Behavioral Sciences)*

Emotional Improvement

Given the physical and cognitive declines seen in aging, a surprising finding is that emotional experience improves with age. Older adults are better at regulating their emotions and experience negative affect less frequently than younger adults and show a positivity effect in their attention and memory. The emotional improvements show up in longitudinal studies as well as in cross-sectional studies and so cannot be entirely due to only the happier individuals surviving *(Mather, M., & Carstensen, L. L., Aging and motivated cognition: The positivity effect in attention and memory. Trends in Cognitive Sciences).*

The concept of *successful aging* can be traced back to the 1950s, and popularized in the 1980s. Previous research into aging exaggerated the extent to which health disabilities, such as diabetes or osteoporosis, could be attributed exclusively to age, and research in gerontology exaggerated the homogeneity of samples of elderly people.

Successful aging consists of three components:
1. Low probability of disease or disability;
2. High cognitive and physical function capacity;
3. Active engagement with life.

(Mather, M., & Carstensen, L. L.. Aging and motivated cognition: The positivity effect in attention and memory. Trends in Cognitive Sciences)

A greater number of people self-report successful aging than those that strictly meet these criteria. Successful aging may be viewed an interdisciplinary concept, spanning both psychology and sociology, where it is seen as the transaction between society and individuals across the life span with specific focus on the later years of life. The terms "healthy aging" "optimal aging" have been proposed as alternatives to successful aging *(Mather, M., & Carstensen, L. L. Aging and motivated cognition: The positivity effect in attention and memory. Trends in Cognitive Sciences)*

Six suggested dimensions of successful aging include:

1. No physical disability over the age of 75 as rated by a physician;
2. Good subjective health assessment (i.e. good self-ratings of one's health);
3. Length of undisabled life;
4. Good mental health;
5. Objective social support;
6. Self-rated life satisfaction in eight domains, namely marriage, income-related work, children, friendship and social contacts, hobbies, community service activities, religion and recreation/sports

Throughout history, humans have been dealing with the aging process. Aging has been viewed differently historically by different societies. In Asia and South America, family members of advanced age are respected for their vast experience and included into the immediate family group. In the United States, which emphasizes youth and energy over age and wisdom, family members of advancing years are placed in nursing homes where they can live comfortably out of sight. However, as the baby-boomer generation rapidly advances in age, Americans will have to rethink their attitudes towards aging. In a rapidly aging society, the bias towards youth will have to be replaced by an added level of respect for the elderly and the values that are important to the aging demographic.

Growing older is an experience we all share and many of us worry about. As we age, we face many changes and many sources of stress -we are not as strong as we used to be, illness is more of a problem, children move away from home, people we love die, we may become lonely, and eventually we must give up our jobs and retire.

Coping with all these changes is difficult, but it can be done. The keys to coping include long-term lifestyle, ability to expect and plan for change, the strength of relationships with surviving family and friends, and willingness to stay interested in and involved with life.

Dealing with Physical Changes

As one grows older, the body will naturally change including tiring more easily, becoming ill more often, and deteriorating sight/hearing.

Coping strategies for physical changes:

- **Accept reality**. Denying these changes will only make life less enjoyable. Get the things that will help such as eyeglasses or hearing aids.

- **Keep a positive attitude**. Remember that slowing down does not mean coming to a complete stop. Chances are that many will still be able to do almost all the things they used to at an adapted pace.

- **See the family doctor regularly**. He/she can, then, deal with any changes or symptoms that require medical attention.

- **Be careful about medications**. As one gets older, they may begin to interact differently with other drugs. Inform the doctor about all medications, even those prescribed by another doctor.

- **Take responsibility for health**. Do not hesitate to ask the doctor questions; some do not offer explanations unless asked.

- **Changing eating habits**. Adopt a balanced diet with fewer fatty foods, and try not to over-eat.

- **Drink less alcohol**. The body will have more difficulty coping with it as one grows older.

Dealing with Bereavement

As we get older, we will likely experience the loss of loved ones more often. It is important to remember the following ways of coping with grief:

- **Do not deny feelings.** Losing someone to death is like being wounded, and healing is necessary. Disallowing the grieving process, only stores up problems for a delayed reaction later on.

- **Accept a range of emotions**. Tears, anger and guilt are all normal reactions.

- **Remember and talk about the deceased person**.

- **Look family and friends for support.** They can provide help through the grieving period and to establish a new life afterwards.

- **Be supportive of those who have suffered a loss.** They need the warmth and caring that friendship can bring.

Dealing with Loneliness

Everyone needs some time alone, but being alone against one's will is very painful. There is a risk of losing sense of purpose, self-worth, and becoming depressed. As family members and friends die and children become more involved in their own lives, it is important to find ways to cope with loneliness. the following coping strategies may be effective:

- **Stay active, and look for new social contacts.** Most communities have a number of programs which can help replace the support that used to be provided by family and life-long friends. These programs provide older people with the chance to try new activities and make new friends.

- **Very young children can brighten up life.** Try to make friends with people of different ages.It may be pleasantly surprising to find how much there is in common with someone 15 or 20 years younger.

- **Spend time with grandchildren and great-nieces and nephews**. Volunteer to help part-time in a local school or day-care centre. Very young children can brighten up life with their enthusiasm and energy.

- **Learn to recognize and deal with the signs of depression**. Loss of appetite and weight, inability to sleep, loss of energy and motivation, and thoughts of suicide are all signs of depression. A family doctor can refer to a mental health professional for treatment.

Dealing with Retirement

Retirement can be a major source of stress because one's job is usually a very important part of life. This stress may be even greater if there has been a forced retirement. Losing a sense of identity and feeling less worthwhile is common. However, retirement can be one of the best times of life, and there are things that can be done to meet the challenges, such as:

- **Make a list of abilities and skills.** The skills and experience gained from a lifetime of work may help with succeeding in a small business or doing valuable volunteer work for a favorite charity.
- **Enrich life by renewing contacts with neglected family members and old friends.** All too often, our work gets in the way of our relationships and those we care about.

- **Renew interest in enjoyable hobbies and activities.** There is now time to enjoy some of these hobbies and activities.

- **If it is affordable, travel.** The early years of your retirement can be the ideal time to become a nomad for a while.

Between 8 to 20 percent of older adults in the community and up to 37 percent in primary care settings suffer from depressive symptoms. These symptoms can range from depressive illness (major depressive disorder, dysthymic disorder, or bipolar disorder) to depressive symptoms that fall short of meeting full diagnostic criteria for a disorder and is associated with an increased risk of developing major depression (subsyndromal depression). In any of these forms, however, depressive symptoms are not a normal part of aging. In contrast to the normal emotional experiences of sadness, grief, loss, or passing mood states, they tend to be persistent and to interfere significantly with an individual's ability to function. Depression often co-occurs with other serious illnesses such as heart disease, diabetes, or cancer.[9] Because of these co-occurring conditions health care professionals may mistakenly conclude that depression is a normal consequence of these problems—an attitude often shared by patients themselves. These factors together contribute to the underdiagnosis and undertreatment of depressive disorders in older people. Depression can and should be treated when it occurs and many effective therapies are available. If left untreated, depression impairs one's enjoyment of life and may increase disability. It can also delay recovery from or worsen the outcome of other co-occurring chronic illnesses.

Cognitive Health
Cognitive health or brain health, is an important part of healthy aging. Cognitive health refers to maintaining and improving mental skills such as learning, memory, decision-making, and planning. Many older adults mistakenly believe becoming "senile" or forgetting is a normal part of aging. Although one in four older adults experiences these events (known collectively as cognitive decline), they are not a normal part of healthy aging. There are certain changes in cognitive health that occur as you age. Normal changes usually mean a slower pace of learning and the need for new information to be repeated. While the majority of older adults will experience these normal changes in cognition, some older adults will experience cognitive decline. Older adults with cognitive decline have a higher risk of developing dementia later in life. Among Americans 65 years and older, approximately 6–10% have dementia, and two-thirds of people with dementia have Alzheimer's disease. Although research has not found a way to prevent dementia or Alzheimer's disease, cognitive decline may be preventable. Recent research suggests that being physically active, controlling your hypertension, and engaging in social activities may help you maintain and improve your cognitive health.

Later in life, the reasons for becoming depressed appear to be obvious and common. The things which we expect to make us feel depressed do become more common as we grow older such as retirement, less income, and perhaps the start of physical problems. There are also the emotional losses such as the death of a partner, family member, friends, or a pet. Surprisingly, less than one elderly person in six feels so depressed that they or others notice. Fewer than one in thirty are so depressed that doctors would diagnose an illness or diagnose a depressive disorder *(Strawbridge, W.J., Wallhagen, M.I. & Cohen, R.D.. Successful aging and well-being: Self-rated compared with Rowe and Kahn. The Gerontologist).*

Symptoms of physical illnesses may be similar to those of Depression. For example, loss of appetite or disturbed sleep may also be caused by physical illnesses, like thyroid problems, heart disease or arthritis.

The Geriatric Depression Scale (GDS)
Depression is common in late life, affecting nearly 5 million of the 31 million Americans aged 65 and older with clinically significant depressive symptoms reaching 13% in older adults aged 80 and older (*Blazer*). Major depression is reported in 8-16% of community dwelling older adults, 5-10% of older medical outpatients seeing a primary care provider, 10-12% of medical-surgical hospitalized older adults with 23% more experiencing significant depressive symptoms (*Blazer*). Recognition in long-term care facilities is poor and not consistent amongst studies (*Blazer*).
Depression is not a natural part of aging. Depression is often reversible with prompt recognition and appropriate treatment. However, if left untreated, depression may result in the onset of physical, cognitive, functional, and social impairment, as well as decreased quality of life, delayed recovery from medical illness and surgery, increased health care utilization, and suicide. While there are many instruments available to measure depression, the Geriatric Depression Scale (GDS), first created by *Yesavage, et al.*, has been tested and used extensively with the older population. The GDS Long Form is a brief, 30-item questionnaire in which participants are asked to respond by answering yes or no in reference to how they felt over the past week. Questions from the Long Form GDS which had the highest correlation with depressive symptoms in validation studies were selected for the short version. Of the 15 items, 10 indicated the presence of depression when answered positively, while the rest (question numbers 1, 5, 7, 11, 13) indicated depression when answered negatively. Scores of 0-4 are considered normal, depending on age, education, and complaints; 5-8

Geriatric Depression Scale: Short Form

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES / NO
2. Have you dropped many of your activities and interests? YES/ NO
3. Do you feel that your life is empty? YES/ NO
4. Do you often get bored? YES/ NO
5. Are you in good spirits most of the time? YES / NO
6. Are you afraid that something bad is going to happen to you? YES/ NO
7. Do you feel happy most of the time? YES / NO
8. Do you often feel helpless? YES/ NO
9. Do you prefer to stay at home, rather than going out and doing new things? YES/ NO
10. Do you feel you have more problems with memory than most? YES/ NO
11. Do you think it is wonderful to be alive now? YES / NO
12. Do you feel pretty worthless the way you are now? YES/ NO
13. Do you feel full of energy? YES / NO
14. Do you feel that your situation is hopeless?

Answers in bold indicate depression. Score 1 point for each bolded answer.
- ❖ A score > 5 points is suggestive of depression.
- ❖ A score ≥ 10 points is almost always indicative of depression.
- ❖ A score > 5 points should warrant a follow-up

indicate mild depression; 9-11 indicate moderate depression; and 12-15 indicate severe depression. The Short Form is more easily used by physically ill and mildly to moderately demented patients who have short attention spans and/or feel easily fatigued.

The GDS may be used with healthy, medically ill and mild to moderately cognitively impaired older adults. It has been extensively used in community, acute and long-term care settings.

The GDS was found to have a 92% sensitivity and a 89% specificity when evaluated against diagnostic criteria. The validity and reliability of the tool have been supported through both clinical practice and research. In a validation study comparing the Long and Short Forms of the GDS for self-rating of symptoms ofdepression, both were successful in differentiating depressed from non-depressed adults with a high correlation (r = .84, p < .001) (*Sheikh & Yesavage*).

The GDS is not a substitute for a diagnostic interview by mental health professionals. It is a useful screening tool in the clinical setting to facilitate assessment of depression in older adults especially when baseline measurements are compared to subsequent scores. It does not assess for suicidality.

The presence of depression warrants prompt intervention and treatment. The GDS may be used to monitor depression over time in all clinical settings. Any positive score above 5 on the GDS Short Form should prompt an in-depth psychological assessment and evaluation for suicidality.

Evidence-Based Practices (EBPs) for Depression in Older Adults?
Depression is one of the leading causes of world-wide disability. Untreated depression can lead to unnecessary suffering, poor health outcomes, high health care costs, and suicide. Effective treatments can reduce the severity of depression in up to 80 percent of older adults. EBPs for treating depression in older adults include: psychotherapy interventions, antidepressant medications, multidisciplinary geriatric mental health outreach services, and collaborative and integrated mental and physical health care. EBPs are interventions that have strong scientific proof that they produce positive outcomes for certain types of disorders. Other interventions– sometimes labeled promising practices – may also produce good outcomes, but research has not been conducted at a level to say that there is strong evidence for those practices. EBPs for older adults with depression are important because their use can:

> ✓ Reduce symptoms of depression
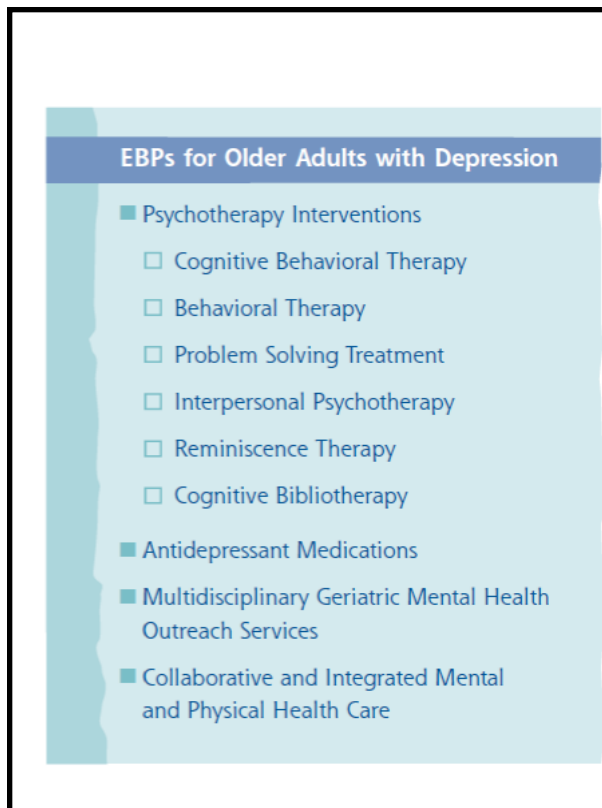> ✓ Improve health
> ✓ Improve functioning

The selection of an EBP depends on the older adult's problems, the outcomes desired, and his or her treatment preferences. For example, both antidepressant medications and psychotherapy interventions are effective in the treatment of depression in older adults. The choice of one of

these interventions over the other may vary with respect to the nature and severity of depression, prior history of effective treatments, the presence of other health conditions or medications, tolerability of side effects or required effort, and the preferences and personal values of the older adult regarding these treatment characteristics.

EBPs for Older Adults with Depression
Four types of EBPs for treating older adults with depression have been systematically evaluated using randomized controlled trials.

➢ **Psychotherapy Interventions:** Psychotherapy is a general term for a method of treating mental disorders by talking about mental health problems and related issues with a mental health practitioner. It's also known as talk therapy, counseling, psychosocial therapy or, simply, therapy or counseling. This KIT describes six psychotherapy EBPs, including cognitive behavioral therapy, behavioral therapy, problem solving treatment, interpersonal psychotherapy, reminiscence therapy, and cognitive bibliotherapy.

➢ **Antidepressant Medications:** Antidepressant medications are used to treat the symptoms of depression. Antidepressant medications act on chemical substances found in the brain, called neurotransmitters, which are deficient or out of balance in persons with depression.

➢ **Multidisciplinary Geriatric Mental Health Outreach Services:** Outreach services provide depression treatment in the homes of older adults or in the locations where older adults frequently spend time, instead of a clinic or office. These services often involve practitioners with different training and skill sets, such as psychiatrists, psychologists, social workers, nurses, or professional counselors. This KIT highlights two models of outreach services, including Psychogeriatric Assessment and Treatment in City Housing (PATCH) and the Program to Encourage Active, Rewarding Lives for Seniors (PEARLS).

➢ **Collaborative and Integrated Mental and Physical Health Care Services:** These programs provide mental health care in the primary health care setting. Programs include collaboration between mental health and physical health care practitioners.

EBPs for Older Adults with Depression

- Psychotherapy Interventions
  - ☐ Cognitive Behavioral Therapy
  - ☐ Behavioral Therapy
  - ☐ Problem Solving Treatment
  - ☐ Interpersonal Psychotherapy
  - ☐ Reminiscence Therapy
  - ☐ Cognitive Bibliotherapy
- Antidepressant Medications
- Multidisciplinary Geriatric Mental Health Outreach Services
- Collaborative and Integrated Mental and Physical Health Care

When selecting which EBPs to add to the array of services in your community or agency, the first set of factors to consider includes:

➢ The severity of depression of the older adults in your target population
➢ Outcomes affected
➢ Service delivery settings
➢ Timeframe of service delivery
➢ Practitioner qualifications and requirements.

Health Status
It is common for older adults to have physical and mental health problems that co-occur with depression. Co-occurring physical health, mental health, and substance abuse problems can affect access and likelihood of response to treatment, as well as treatment preferences and outcomes. Many studies that test the effectiveness of a treatment place restrictions on the older adult participants. Studies may exclude older adults with cognitive impairment or substance abuse problems. Some studies also exclude older adults with co-occurring physical health or mental health disorders. A treatment might work equally well for people with and without co-occurring health problems; however, you will want to carefully monitor the outcomes to

ensure that the program works for both groups of people. The effectiveness of psychotherapy interventions for older adults with depression has been systematically reviewed by several groups of scientists.

Cognitive Behavioral Therapy (CBT) for Older Adults
CBT can be provided by professional mental health practitioners, including psychiatrists, psychologists, social workers, psychiatrically trained nurses, and licensed marriage and family counselors.

Diagnoses or Disorders Addressed
- ➢ Major Depression
- ➢ Minor Depression
- ➢ Dysthymia
- ➢ Depressive symptoms, as indicated by 10 or greater on the Hamilton Rating Scale for Depression, 10 or greater on the Beck Depression Inventory, or 11 or greater on the Geriatric Depression Scale
- ➢ Moderate to severe symptoms of depression, as indicated by 69 or greater on the Zung Self-rated Depression Scale.
- ➢ Subclinical symptoms of depression CBT also has been tested in older adults with anxiety disorders and schizophrenia

Manual Availability
CBT was developed by *Beck and colleagues* and has been adapted for use with older adults.
- Gallagher-Thompson, D., Steffen, A.M., & Thompson, L.W. (Eds.). Handbook of behavioral and cognitive therapies with older adults. New York: Springer. This volume reviews the evidence base for CBT with common mental health problems of later life (e.g., depression, generalized anxiety disorder, substance abuse) and with less common problems (e.g., schizophrenia, bipolar disorder, suicide ideation). Chapters also discuss the application of CBT to pain management, insomnia, personality disorders, dementia, and grief reactions.

- Laidlaw, K., Thompson, L., Dick-Siskin, L., & Gallagher-Thompson, D. Cognitive behavior therapy with older people. United Kingdom: John Wiley & Sons Ltd.

- Beck, J. S., Cognitive Therapy: Basics and Beyond. New York: Guilford Press.

- Wright, J. E., Basco, M. R., & Thase, M. E. Learning Cognitive-Behavior Therapy: An Illustrated Guide. Washington, D.C.: American Psychiatric Publishing, Inc.

CBT has been implemented in many locations across the country by practitioners who are trained in this practice. CBT also has been combined with case management for low-income older adults, and was found to be more effective than CBT alone (*Areán and colleagues*). The principles of CBT have been used to develop an intervention for Mandarin-speaking Chinese Americans. The intervention is delivered in eight two-hour classes (*Dai and colleagues*).Numerous studies also have been conducted with distressed and/or depressed family caregivers who provide hands-on care to an older relative with Alzheimer's disease or another form of dementia. The evidence base for the success of the application of CBT with this population, on, including with ethnic minority caregivers, is found in a comprehensive review by *Gallagher-Thompson and Coon*.
A form of CBT, called *Coping With Depression*, has been adapted and provided in the Netherlands (*Haringsma and colleagues*). The Coping With Depression (CWD) course can be effectively delivered to older adults as an in-person or internet-based program (*Spek and colleagues*).

Behavioral Therapy (BT) for Older Adults
Behavioral Therapy (BT) is a structured, time-limited therapy. It examines the relationship between a person's behaviors and their mood. BT conceptualizes depression as the result of a lack of pleasant events and an excess of unpleasant events in a person's life. BT is typically delivered in up to 18 one-hour group or individual sessions that occur in a clinical setting. During sessions of BT, the practitioner teaches older adults to:

- ➢ Monitor their mood
- ➢ Record pleasant and unpleasant events
- ➢ Notice the connection between pleasant events and positive mood, and unpleasant events and negative mood, and
- ➢ Identify and increase participation in pleasant events

Diagnoses or Disorders Addressed
- ➢ Major Depression
- ➢ Minor Depression

➢ Depressive symptoms, as indicated by 10 or greater on the Hamilton Rating Scale for Depression, 10 or greater on the Beck Depression Inventory, or 11 or greater on the Geriatric Depression Scale.

Evidence and Outcomes
➢ Five randomized controlled trials have been conducted by multiple researchers.
➢ BT is an established effective treatment for older adults with depression, compared to no treatment or typical care. BT is effective in reducing depression symptoms and in improving the older adult's life satisfaction and coping strategies.

Problem Solving Treatment (PST) for Older Adults
Problem Solving Treatment (PST) is a psychotherapy that is designed to help older adults develop skills for dealing with stress and feelings of depression. PST can be delivered by a variety of health, mental health, and social service practitioners in mental health, long-term care, residential, and primary care settings. PST is delivered in 12 or fewer sessions outlined in a manual. Training can be conducted over a relatively short number of training sessions. It is effective in treating depression in older adults.

Problem Solving Treatment (PST) is a short term, intensive intervention where the older adult and the practitioner (often a nurse or social worker) identify problems that the older adult is facing and develop an action plan to solve the problems. PST encourages older adults to identify a particular goal to reduce depression and teaches a systematic and objective approach to working on problems. PST is based on the idea that deficiencies in social problem-solving skills increase the risk for symptoms of depression. PST trains older adults to develop an effective and adaptive approach for solving problems and coping with problems that lead to mental distress. Several concrete steps are associated with PST. These include:
➢ Clarify and define the problem
➢ Set a realistic goal
➢ Generate multiple solutions
➢ Evaluate and compare solutions
➢ Select a feasible solution
➢ Implement the solution
➢ Evaluate the outcomes

PST is typically delivered in 12 or fewer one-hour sessions.PST can be provided by trained practitioners with a bachelor's degree or higher who work in the health or social service professions. The model has been developed specifically for non-mental health settings, like primary care medicine, so that the intervention could be delivered by a variety of health care professionals, regardless of their mental health background.

Diagnoses or Disorders Addressed
➢ Major depression
➢ Minor depression
➢ Dysthymia
➢ Severe depression symptoms, as indicated by a CES-D score of 22 or greater, or mild to severe depression symptoms as identified by the Beck Depression Inventory.

Interpersonal Psychotherapy (IPT) for Older Adults
Interpersonal psychotherapy (IPT) is a structured, time-limited therapy. IPT is based on the idea that interpersonally relevant issues often precede depression and that depression can lead to interpersonal problems. IPT focuses on current interpersonal relationships within four areas. Treatment can address one or more of these areas.
➢ Unresolved Grief (complicated bereavement): the practitioner facilitates mourning and helps the older adult find new activities and relationships to compensate for the loss,
➢ Role Transition (major life change): the practitioner helps the older adult deal with change by recognizing the positive and negative aspects of the new and old roles and adapting to the new role,
➢ Interpersonal Role Disputes (conflict with another person): the practitioner helps the older adult understand the relationship, the nature of the dispute, and options to resolve and
➢ Interpersonal Deficits (problems initiating or sustaining relationships): the practitioner helps the older adult identify problematic social skills and improve these skills within the context of the therapeutic frame.

IPT uses several techniques to bring about change. These include elements of exploration, clarification, and encouragement of affect; communication analysis; role playing; extensive psycho education about the bio-psychosocial model of depression; and encouragement of alternative coping strategies.

IPT is typically delivered in 16 (and sometimes fewer) individual sessions that are held weekly for 50 to 60 minutes. IPT is divided into three phases.

1) In the first three sessions of IPT, a diagnosis of depression is made and explained, an inventory of social relationships is collected, recent interpersonal problems are identified, and the goals of treatment are set
2) In the intermediate sessions (sessions 4-13), the practitioner works with the older adult to address the interpersonal problem(s).
3) In the termination sessions (sessions 14-16), the course of treatment is reviewed and feelings associated with the end of treatment are discussed. The older adult is encouraged to develop ways to identify and address symptoms of depression if they should arise in the future.

Practitioners IPT can be delivered by mental health care professionals, including psychiatrists, psychologists, social workers, and nurses.

Diagnoses or Disorders Addressed
➢ Major Depression
➢ Minor Depression
➢ Sub-Dysthymic Depression, as defined by depressive symptoms (Geriatric Depression Scale score greater than 10) without meeting diagnostic criteria for major depression or dysthymia.

Cognitive Bibliotherapy (CB) for Older Adults
Cognitive bibliotherapy is a self-directed psychotherapy that is designed to change the thought patterns that cause or maintain depression. It is delivered through self-guided written materials, which are complemented by oversight from a mental health practitioner. No formal treatment manual is available as this is a self-directed intervention. Cognitive bibliotherapy is effective for treating mild or moderate levels of depression in older adults.

Cognitive bibliotherapy involves reading books and completing written exercises in order to learn about depression and ways to reduce its symptoms. Reading materials and written exercises are completed outside of a clinic setting, often at the participant's home and at the participant's own pace. Similar to cognitive behavioral therapy (CBT), cognitive bibliotherapy is intended to change the thinking and behaviors that cause or maintain depression. The book Feeling Good, by David Burns, was read by older adults in all studies of cognitive bibliotherapy published to date. After learning to monitor depressive symptoms, readers are introduced

to the concept of cognitive distortions and to techniques designed to help them question depressive thoughts and improve their mood. Feeling Good is divided into seven parts entitled:

➢ Theory and research
➢ Practical applications (i.e., building self-esteem, defeating guilt),
➢ Realistic depressions (i.e., depression is not sadness),
➢ Prevention and personal growth defeating hopelessness and suicide,
➢ Coping with the stresses and strains of daily living, and
➢ The chemistry of mood (i.e., the mind-body connection, antidepressant medications).

Older adults can complete a course of cognitive bibliotherapy over a four-week period. During this time, it is important that practitioners with expertise in depression and CBT have brief, weekly contact with the older adult. Cognitive bibliotherapy can be an accessible alternative to formal mental health interventions in clinic-based settings. This may be particularly relevant to older adults, who traditionally have underutilized mental health treatment.

Cognitive bibliotherapy is completed by the older adult. For ethical and practical reasons, completely self-administered programs for older adults with depression are not advised (*Scogin and colleagues*). Practitioners with expertise in depression and CBT should provide at least minimal contact with the older adult.

Diagnoses or Disorders Addressed
➢ Major depression
➢ Minor depression
➢ Dysthymia
➢ Mild to moderate depressive symptoms, as indicated by a score of 10 or greater on the Hamilton Depression Rating Scale, or 11 or greater on the Geriatric Depression Scale.

Reminiscence Therapy (RT) for Older Adults
Reminiscence therapy for older adults is a technique that is designed to help older adults resolve conflicts and accept their successes or failures. It is generally provided in long-term care facilities, senior housing, and senior community centers by trained nurses and therapists. It is effective in treating mild levels of depression. Technical assistance and published protocols are available.

Reminiscence therapy involves the discussion of past activities, events and experiences with another person or group of people. It can be provided in many forms in order to prevent, assess, and intervene with depression and other mental health issues. Structured reminiscence approaches include *Life Review and Guided Autobiography.*

The concept of Life Review was first published by Robert N. Butler in 1963. The life review process helps older adults resolve conflicts and accept both the successes and failures of their lives. In the life review process, practitioners use weekly topics to guide older adults in recalling memories from different stages of their lives and to stimulate discussion of major life events. These processes are thought to promote feelings of control over past and present life events by counteracting learned helplessness.

Structured Reminiscence Therapy is typically provided in a group setting, led by a mental health practitioner, and occurs over four to twelve weekly sessions that last 60–90 minutes. There are several potential benefits of reminiscence approaches.
- ✓ Reminiscence approaches can be used during the assessment process to bolster older adults' confidence and self-esteem.
- ✓ Reminiscence can be integrated into a number of treatment approaches, including cognitive behavioral therapy. These approaches are effective in individual, group, marital/family, and milieu therapy modalities.
- ✓ Practitioners can use reminiscence materials to develop therapeutic resource states that facilitate change.
- ✓ Reminiscence approaches can help obtain and maintain attention and rapport for those who want to educate older adults about mental health issues.

Reminiscence therapy can be provided by practitioners who have received training in reminiscence therapy. Practitioners can include mental health professionals, nurses, chaplains, and other members of a multi-disciplinary team. Practitioners should integrate their reminiscence approaches within their theoretical approach and treatment plan.

Diagnoses or Disorders Addressed
- ➢ Major Depression

➢ Depressive symptoms, as indicated by a Geriatric Depression Scale (GDS) score of 14 or greater, or 16 or greater on the CES-D.

Reminiscence therapy has been used to prevent and assess mental health disorders. It has been used in older adults with anxiety and health conditions that cause anxiety; behavioral problems due to dementia, delirium, or other physical health disorders; normal and unresolved grief; and substance abuse. Reminiscence therapy also has been tested in older adults with dementia.

Antidepressant Medications
Antidepressant medications are provided by health care practitioners who are licensed to prescribe and monitor medications. They are effective in treating depression in older adults. Antidepressant medications are the most commonly used intervention for the treatment of depression in older adults. Most antidepressant medications are prescribed by primary care practitioners as the primary treatment for depression. For some older adults, the combination of psychotherapy and antidepressant medications may be more effective than antidepressant medication alone (*Thompson and colleagues*) and may prevent or delay the recurrence of depression (*Reynolds and colleagues*). Medication treatment may be the most appropriate treatment for some people with depression. This may include older adults who have depression with psychotic symptoms, severe depression that has responded to antidepressant medications in the past, or severe depression that does not respond to psychotherapy. Medications also may be most appropriate for older adults with depression and dementia or another cognitive impairment that limits their ability to benefit from psychotherapy.

Although many older adults with major depression prefer psychotherapy (*Gum and colleagues*), there are several reasons why older adults may prefer to receive antidepressant medications. Older adults may prefer medications if they do not wish to attend multiple psychotherapy sessions. For the older adult, multiple psychotherapy sessions may be associated with challenges in transportation, physical mobility, cognition, cost, and stigma perceived in attending appointments with a mental health practitioner. Psychotherapy also may be inaccessible in some locations where older adults receive care. The 50 percent Medicare co-payment for outpatient psychotherapy also may have been a substantial barrier to the use of psychotherapy for some older adults.

Antidepressant medications are administered as pills that are prescribed by a health care practitioner. Antidepressant medications act on chemical substances found in the brain, called neurotransmitters, which are deficient or out of balance in persons with depression. Antidepressants medications may work by improving the levels of neurotransmitters that support the functioning of brain cells. A particular antidepressant medication is selected on the basis of the characteristics of the older adult, the least likelihood of problematic side effects, and any past personal or family history of responding to specific antidepressant medications. The health care practitioner regularly monitors the patient and adjusts the medication dosage accordingly. For example, a partial treatment response may require increasing the dose of the antidepressant, or switching to a different antidepressant. The development of common side effects such as sedation, insomnia, agitation, or nausea may indicate the need to decrease the dose consider a different antidepressant if these side effects do not resolve or if they worsen over time. Finally, the development of more serious side effects such as confusion, irregular heart rhythm, marked increase or drop in blood pressure, falls, or allergic responses to medication require immediate medical attention. A variety of types of antidepressant medications can reduce symptoms of depression in older adults. For example, selective serotonin reuptake inhibitors (SSRIs) are often effective in treating depression. SSRIs include Celexa (citalopram), Lexapro (escitalopram), Luvox (fluvoxamine), Paxil (paroxetine), Prozac(fluoxetine), and Zoloft (sertraline).

Tricyclic antidepressants (TCAs) are an older and sometimes less expensive type of medicine for depression. These drugs are effective, but may have side effects that can be particularly trouble in older persons such as increased falls due to a drop in blood pressure on standing, irregular heart rate, confusion, or urinary retention.

Monoamine oxidase inhibitors (MAOIs) are another group of older antidepressant medications that are rarely prescribed, and only in situations when other antidepressants have failed. MAOIs are generally contraindicated in older adults as they can be associated with falls due to low blood pressure or dangerous episodes of extremely high blood pressure when taken with particular foods (e.g., aged cheese, Chianti wine) or medications (e.g., SSRIs, stimulants, cough medications, painkillers). Other non-SSRI antidepressants include Cymbalta (duloxetine), Desyrel (trazadone), Effexor (venlafaxine), Serzone (nefazodone), Remeron

(mirtazapine), and Wellbutrin (bupropion).

Table 4: Common Antidepressant Medications for Older Adults

	Brand Name	Generic Name
Selective Serotonin Re-uptake Inhibitors		
	Celexa	Citalopram
	Lexapro	Escitalopram
	Luvox	Fluvoxamine
	Prozac	Fluoxetine
	Paxil	Paroxetine
	Zoloft	Sertraline
Tricyclic Antidepressant Medications		
	Aventyl, Pamelor	Nortriptyline
	Norpramin	Desipramine
Monoamine Oxidase Inhibitors		
	Nardil	Phenelzine
	Parnate	Tranylcypromine
Non-SSRI Antidepressant Medications		
	Cymbalta	Duloxetine
	Desyrel	Trazadone
	Effexor	Venlafaxine
	Remeron	Mirtazapine
	Serzone	Nefazodone
	Wellbutrin, Zyban	Buproprion

Antidepressant medications are one of the most widely available treatments for older adults with depression. They are available in physical health and mental health care settings that have practitioners who are licensed to prescribe medications.

Antidepressant medications can be provided by health care professionals who are licensed to prescribe medications (e.g., psychiatrists, primary care practitioners, nurse practitioners, and psychologists – psychologists have prescribing privileges in New Mexico and Louisiana).The common occurrence of major physical health conditions, multiple medications, and

greater sensitivity to side effects experienced by older adults requires that a medical evaluation and review occur before antidepressants are prescribed, followed by ongoing medical supervision.

Diagnoses or Disorders Addressed
- ➢ Major Depression
- ➢ Minor Depression
- ➢ Dysthymia
- ➢ Antidepressant medications also are effective in older adults with Unipolar Depression and Non-specified Depression.

5. Geriatric Clinical Considerations

Butler, Lewis, and Sunderland noted that a "demographic revolution" is underway in the United States in which members of the so-called "baby boomer" generation entering the period after age 65 will eventually comprise about 20 percent of the national population. Older individuals, male and female, wealthy and poor, urban and rural, will consume a disproportionate level of care resources in the coming decades.

This "demographic revolution" demands that counselors and therapists develop effective intervention strategies for assisting older clients in coping with the myriad issues that confront the elderly. This following will address some of the key issues related to this process, including ageism itself, counter transference and transference issues in counseling, psychiatric problems including dementia, assessment techniques, and "best practice" interventions.

Agism is a general term that encapsulates the prejudices and stereotypes that are applied to older people purely on the basis of their age (*Butler, et al*). Ageism is a construct that functions to "pigeonhole" people in much the same manner as sexism and racism; in essence, ageism is a way of thinking about the elderly that marginalizes them, demeans them, and isolates them. Ageism begins in childhood, according to *Butler, et al*, and represents in part an attempt by younger people to shield themselves from the recognition that they, too, will eventually age and confront the inevitability of death and physical decline.

The effects of ageism are numerous and potentially debilitating. Ageism can constitute the societal sacrifice of older people for the sake of younger

people. In the workplace and in the family unit, older individuals (i.e., those over age 65, which is an admittedly arbitrary cutoff for defining the "elderly") are often dismissed as unable to make adequate contributions to the group. Ageism also encompasses the assumption, common even among counselors and other caregivers, that older individuals have lost much of the capacity for self-management and self-care that characterizes younger individuals.

Agism also incorrectly assumes that the process of aging is invariably associated with a decline in mental and physical competencies. It can and does provide a rationalized excuse for forcing older workers to retire. In the United States, federal legislation has been enacted to prevent age discrimination in the workplace, but many older workers still find that they are devalued and passed over for promotions or other benefits simply because of negative assumptions regarding their age and its putative impact upon performance (*Butler, et al*).

In the context of counseling and therapy, ageism can negatively impact upon the capacity of professional caregivers to work effectively with clients. Attributions of individual traits, behaviors, needs, or other issues addressed in the context of counseling can distort the process itself. For mental health caregivers, serving the older client necessitates coming to terms with one's own fears and anxieties regarding the aging process (*Butler, et al*).

Counter-transference and Transference
In providing services to the older client, a counselor must be aware of the issues associated with both transference and counter-transference. Counter-transference is described by *Butler, et al* as follows:

> *Counter-transference in the classic sense occurs when mental*
> *Health personnel find themselves perceiving and reacting to older persons in*
> *ways that are inappropriate and reminiscent of previous patterns of relating to*
> *parents, siblings, and other key childhood figures. Love and protectiveness may*
> *vie with hate and revenge. Ageism takes this a step further. Mental health*
> *personnel not only have to deal with leftover feelings from their perceptions of*
> *older persons, but they must also be aware of negative*
> *cultural attitudes toward older persons.*

Central to the therapeutic relationship, regardless of the age, gender, or ethnicity of the client and therapist, are the processes of both transference and counter-transference. In transference, as the class lectures and

discussions demonstrated, clients often come to regard their counselor or therapist as an authority figure or another or loved or hated figure from the past. Often, clients will transfer their previous attitudes toward significant others in their lives to the therapist.

The older client may display an overwhelming desire to please the analyst, or may also display resentment and hatred even though the analyst has done nothing to provoke such emotions. Transference allows the therapist to identify a pattern of the unconscious problems that the client is experiencing and can therefore be valuable in facilitating the therapeutic process.

Counter-transference may be more difficult in the context of dealing with older clients. *Butler, et al* pointed out that some aged clients may stimulate therapists' fears about his or her own old age, arouse the therapist's conflicts about relationships with parental figures, or suggest to the therapist that intervention is wasted effort because the older client may be nearing death. When therapists working with elderly clients allow negative attitudes to intervene, therapy cannot be successful.

In other words, therapists must avoid negative counter-transference based on ageism as well as an unconscious over identification with older people. Certainly, the therapist working with older patients must recognize that simply being elderly does not mean that an individual's capacity for enjoying life, making a meaningful contribution to family and society, or participating competently in problem resolution cannot occur.

Psychiatric Problems, Dementia
Older individuals may present for treatment with any one of a number of psychiatric problems. Anxiety of an acute or chronic nature, substance abuse engendered by over-medication, depression, difficulties with activities of daily life (ADLs), and social isolation are among these problems. Older adults may experience all of the neuroses and psychoses that are found in younger patients, including schizophrenia and paranoid disorders manifested by delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, or negative symptoms (*Butler, et al*).

Mood disorders, including major depressive disorder, bipolar disorder, and dysthymic disorder are also observed in older individuals, as are the various somatoform and personality disorders. *Butler, et al* reported that the American Psychiatric Association estimates that between 15 and 25 percent

of all individuals over the arbitrary age of 65 suffer from symptoms of mental illness. Of those older people with mental disorders, depression appears to be the most common primary diagnosis.

Dementia is one of the most frequently observed forms of mental illness in older patients. While it is certainly true that there are often organic explanations for psychoses suffered by older individuals, it is also true that the vast majority of older individuals suffering from psychiatric disorders do not have mental problems as a result of physiological conditions. It is all too often assumed that any psychiatric symptoms that arise in later life are secondary to the problems of aging itself. Because this is the case, older patients, including those in residential or institutional facilities who are known to have psychiatric disorders tend to be undertreated.

It is fallacious to assume that the physical health problems that emerge as individual's age invariably give rise to psychiatric disorders (*Butler, et al*). It is far more likely that older individuals experience psychiatric problems as a consequence of legitimate fear of being alone, a sense of social isolation, a feeling of worthlessness, and any number of other anxiety-producing sociocultural or familial situations. Mood disturbances such as depression are of particular significance because the depressed individual also experiences sleep disturbance, appetite and weight changes, decreased concentration, feelings of fatigue or loss of energy, psychomotor disturbances, and recurrent thoughts of death (*Butler, et al*).

For the older individual it may very well be that this type of mental illness (i.e., depression) exacerbates physiological anomalies or health problems. Dementia and the various psychoses, according to discussions in class and lectures, represent a break in the ability to manage the activities of daily living and a lack of reality testing. This may occur in the older person as a consequence of multiple losses within a close time period or as a reaction to certain extreme stresses.

In other words, the therapist or counselor working with the older individual must recognize that these individuals will manifest many of the same presenting problems exhibited by younger clients. Dismissing these problems as an artifact of the aging process or declining health status is inappropriate. The older individual is as worthy of intervention as any other client.

Assessments

Older clients should be as thoroughly assessed or evaluated as any other particular population. Geriatric assessment is a multidisciplinary evaluation in which the multiple problems of older persons are identified, described, and explained. The resources and strengths of the individual are identified, service needs assessed, and a coordinated care plan developed in order to focus interventions (*Butler, et al*).

It is important to recognize that the older individual needs a multidisciplinary assessment in which a number of professionals pool their knowledge and expertise to construct as complete profile of the psychiatric, physical, social, financial, and other problems of the older client as is possible. Such assessments fulfill preventive and screening functions as well as diagnostic functions.

For therapists working with geriatric patients, assessment and evaluation procedures and tools are important elements in the avoidance of counter-transference. A thorough assessment as described above can help a therapist to overcome any preconceptions or stereotypes that he or she may possess regarding the aged. Medical as well as psychiatric assessment and the taking of a complete case history combine to assist the therapist in developing an effective intervention plan.

Interventions

Interventions designed to meet the needs of older clients can range from pharmaceutical treatment to psychotherapy and environmental therapy, other somatic therapies, cognitive and behavioral therapies, reality-orientation, re-motivation, and rehabilitation programs, to assistance with ADLs. What is essential in designing any intervention for the older client is pinpointing what is threatening the client and what they are reacting to.

The counselor should be careful not to argue with the client or attempt to impose his or her version of what is or is not the truth about the problem as the client sees it. Doing so can increase the fear of the older adult and jeopardize the development of the kind of rapport needed in the therapeutic relationship. The goal of intervention, whatever form it might take, is to contain any paranoid, anxious, or other self-damaging reaction that the older client has to his or her problems. A related goal is addressing the underlying problem and ensuring that interventions designed to ameliorate or eliminate that problem are forthcoming.

Process becomes more important than content in this therapist/client relationship. Process may be defined as dealing with or addressing the underlying verbal or nonverbal feelings expressed by the client. Warmth and empathy without condescension are essential aspects of the therapist's behavior and attitudes. Realistic treatment goals should be set via consultation with the client and other caregivers. Assisting the older person who has lost a loved one, for example, may involve addressing issues of guilt and atonement as well as the client's personal fears regarding illness or death. In any event, interventions that are successful with older clients are those that are framed to meet specific needs and result in positive improvements in mood, affect, outlook, and functioning.

The field of geriatric counseling is an increasingly important practice focus because of the aging of the American population. It is likely that members of the care giving professions will devote even more time to research on the best practices for treating this population effectively.

What emerges from this discussion is the recognition that the older individual is entitled to caring, supportive, and non-prejudicial service from a counselor. Moving from a thorough assessment of the client's need to a multidisciplinary set of interventions offered in an empathetic and caring manner is essential. Avoiding counter-transference is necessary and can be helpful to the therapist in confronting his or her own concerns regarding the aging process.

6. Intimate Partner (IPV) and Domestic Violence (DV) Later in Life

As the Baby Boom generation born between 1946 and 1964 ages, it is likely more victims of late life violence and abuse will seek out or be referred to the specialized services provided by IPV programs. This potential calls for increased collaboration between aging and domestic violence networks to assure maximum support and safety for victims and survivors of abuse in later life. The national aging network of State Units on Aging, Area Agencies on Aging, Tribal and Native organizations, and direct service providers—especially long term care ombudsman programs, adult protective services, legal services, and information and referral/assistance—has a key role to play in speaking out for older victims.

IPV later in life occurs when older individuals are physically, sexually, or emotionally abused, exploited, or neglected by someone [with whom] they have an ongoing relationship. . . . Abusers intentionally use coercive tactics, such as isolation, threats, intimidation, manipulation, and violence to gain and maintain control over the victim. No matter what the victim's age, abusers' tactics are remarkably similar. Abusers frequently look for someone they can dominate, people believed to be weak, people unlikely or unable to retaliate. With respect specifically to abuse in later life, the aggressors include spouses and former spouses, partners, adult children, extended family, and in some cases caregivers. As victims' advocates know well, abusive behaviors such as punishing, isolating, or depriving are at root about a desire for power and control. Power is used to control where the victim goes, who the victim sees, what the victim can or cannot2 do; decision-making is curtailed; property and financial resources are exploited. A sense of entitlement often underlies the abusive behavior. The problem of abuse in later life occurs in all communities and affects people of all ethnic, cultural, racial, economic, and religious backgrounds. Although most victims are female, older men can be harmed, too. IPV in later life and elder abuse often go hand in hand, and the consequences on lives are very similar. Elder abuse, broadly speaking, includes physical, emotional, sexual abuse, financial exploitation, neglect, self-neglect, and abandonment of older persons — terms defined by law in state adult protective services (APS) statutes. APS laws in most states address the needs of vulnerable adults over the age of 18 who are living alone or with family and who are at risk of abuse, neglect, or exploitation. The network on aging is charged with the responsibility under federal law to serve as a visible advocate for older Americans age 60 and over.

About the Aging Network
The national aging network, established by Congress under the Older Americans Act (OAA), is composed of 56 State Units on Aging, over 600 Area Agencies on Aging, and thousands of public and private local service providers across the country. The U.S. Administration on Aging, an office within the Department of Health and Human Services, administers most OAA programs at the federal level. The aging network serves as a main gateway to OAA programs and to the many services supported by other federal, state and private sources. As a focal point, the network coordinates access, community long-term care, and supportive services for older Americans and their families. The array of services offered through the

aging network varies from state to state and county to county; however, the basic structure of the aging service system is consistent throughout the country. State Units on Aging (SUAs) are agencies of state and territorial governments designated by governors and state legislatures to administer, manage, design and advocate for benefits, programs, and services for the elderly and their families and, in many states, for adults with physical disabilities. In addition to overseeing Older Americans Act-funded programs, SUAs have significant policy, planning and advocacy roles in leveraging other federal, state, local, public, and private funds to support programs on aging. Two-thirds of the SUAs administer their state's Medicaid waiver program (often called a home and community-based service waiver), a program which aims to help people in need of significant daily activity support and health services to receive care at home. In over half the states, the SUA administers adult protective services. Some SUAs are members of state domestic violence councils. Some convene or participate in intergovernmental working groups focused on older victims. Each SUA has a staff member who has been designated the elder abuse contact at the state level. State elder abuse contacts can provide consultation on the development of aging network partnerships and collaborations.

Area Agencies on Aging (AAAs) play a pivotal role in communities across the country in planning and developing services to respond to local needs. The AAAs support a range of services in the community including legal assistance, in-home services, information and referral/assistance, client assessment and care management, senior centers, adult day care services, transportation, caregiver support, congregate meals, meals on wheels, chore and homemaker services, telephone reassurance, and friendly visiting. In some states, AAAs are responsible for the delivery of adult protective services. These services include receiving and investigating reports of elder abuse. Most AAAs conduct elder abuse prevention activities such as public education campaigns, training for mandated reporters and educational conferences. Guardianship and money management programs, supported by AAAs in some areas, are examples of services intended to protect those most at risk of abuse.

The AAA is the principal contact point for domestic violence programs interested in local collaboration. Use the National Eldercare Locator 1 800–677-1116 or visit www.eldercare.gov to identify the AAA for your area. The Locator is a national, toll-free telephone referral service connecting callers with state and local agencies on aging and community services.

Aging Network Services at a Glance

The services available through the aging network offering support to victims of late life domestic violence and elder abuse fall under four broad categories:
1. Access services
2. Elder rights
3. Services in the community
4. In-home services

Information and Referral Assistance (I&R/A)
Millions of older people and their families around the country receive assistance each year from a network of more than 3,000 aging I&R/A programs and services. Many state agencies on aging have toll-free 800 aging I&R help lines—and in some areas state and local Long Term Care Ombudsman programs share a common intake line with the aging I&R/A. Individuals can also call the AAA for information on services and resources available locally. Most aging I&R/A databases provide information on a wide variety of critical health and human services. Increasingly, these databases are readily available to the public online. Find out if the aging I&R/A in your area has information about domestic violence services. If not, request to have local contact information included.

State Health Insurance Counseling and Assistance Programs
The State Health Insurance Counseling and Assistance Program, or SHIP, has trained volunteer counselors in every state and several territories who are available to provide free one on-one help with Medicare questions or problems. To locate a program in your area, visit www.medicare.gov/contacts/static/allStateContacts.asp SHIP services can be especially helpful for late life domestic violence victims —in particular adults with disabilities under age 60 who have experienced problems with Medicare, and those not yet enrolled.

Elder Rights/Legal Assistance
Legal services help those who could not otherwise afford an attorney to obtain advice, information, and limited representation in civil law matters such as financial abuse and exploitation, consumer problems, advanced directives, and guardianship. These services are primarily provided by local legal services entities in the community funded by AAAs. At the state level,

every SUA has a State Legal Service Developer on staff to coordinate the provision of legal assistance. State and area agencies on aging work to expand legal service availability through coordination with state/local bar committees, the development of pro bono or reduced-fee panels and through coordination with grantees of the Legal Services Corporation. Many states also operate statewide legal hotlines. Older Americans Act-funded legal services are free; however, the demand for services far exceeds the dollars available. To meet the needs in the community, many programs establish case intake priorities. The AAA can provide more information about legal resources for older persons in the area.

The following are examples of possible legal remedies for victims of late life violence or elder abuse:

- Assisting a victim to enter into a new power of attorney arrangement and/or revoke authority of an existing attorney in fact (the individual who holds a power of attorney).
- Terminating the powers of a guardian who has abused his or her role.
- Providing defense for a proposed ward in a guardianship proceeding if an abuser is attempting to gain control without looking out for the ward's best interests.
- Returning title to a victim's name for property, vehicles, certificates of deposit, or bank accounts that were taken by a perpetrator.
- Filing an action to recover property or money wrongfully taken.
- Obtaining a restraining order or injunction to stop a perpetrator.
- Establishing a trust to protect the resources of a victim.
- Changing a will back to a testator's/victim's wishes from the changes made by a perpetrator.
- Appealing a denial of public benefits, Social Security, or disability decision.
- Filing for a name change.
- Filing an order for removal of a perpetrator from a victim's property. The American Bar Association's Law & Aging Guide can help you find a senior legal services program in your area. You can search by state online at www.abanet.org/aging/statemap.html

Long Term Care Ombudsman Program
Long term care ombudsmen at both the state and local levels advocate for and protect the rights of residents in nursing and care homes. Ombudsmen investigate and work toward resolution of complaints about care voiced by residents or their family members. Federal law requires all states to have a

Long Term Care Ombudsman Program. A contact directory of state ombudsman offices is available on the National Long Term Care Ombudsman Resource Center Web site www.ltcombudsman.org

 Domestic violence doesn't necessarily stop when a victim enters a nursing, assisted living, or care home. In many instances, the ombudsman can identify and respond to these situations. The ombudsman can also be a resource to a victim of domestic violence who has a family member in a nursing home. Similar to domestic violence intervention, the ombudsman focus is to clarify and carry out the wishes of the resident. All communications between the resident and the Ombudsman are confidential. Ombudsmen and domestic violence programs will likely benefit from joint training to promote greater understanding and collaboration.

Elder Abuse Prevention and Coalitions
Community and state advocates all around the country are working to educate the public and increase understanding about elder abuse. In addition to offering various resources on elder abuse such as brochures, wallet cards with reporting numbers, posters, and service directories, state and area agencies on aging help sponsor and organize multidisciplinary conferences, training, and outreach presentations for community leaders, advocates, allied professionals, and concerned citizens. Aging network agencies also lead, coordinate, and participate in state and local elder abuse coalitions. Membership in these coalitions includes law enforcement; prosecutors; adult protective services; representatives from the health care sector; emergency medical services; and other key partners. Often the coalitions develop community projects to increase understanding and outreach to elder abuse victims. Elder abuse prevention activities are mandated by the Older Americans Act. Domestic violence programs, if not already involved in a state or local elder abuse coalition, are encouraged to inquire about becoming a member. Similarly, to promote collaboration and exchange, invite participation of elder abuse partners in state and local domestic violence task forces and coordinating councils.

Adult Protective Services
Adult protective services are authorized under state law. Support is provided to both older and at-risk vulnerable adults who are in danger of being abused or neglected, or who are unable to protect themselves and have no one to assist them. Services include but are not limited to receiving and investigating reports of abuse, neglect or exploitation, legal advocacy, and

providing or arranging for community services such as emergency shelter. Service plans are developed for victims who agree to receive help. If the victim is unable to make decisions because of mental illness or dementia and is at risk of continuing harm, adult protective services may provide emergency services and/or petition the court for the appointment of a guardian advocate. The AAA in some areas of the country is the local provider of adult protective services; in most states, however, the county social service agency is assigned responsibility. Domestic violence programs seeking to improve services for victims of late life violence and abuse are encouraged to coordinate with both sectors. Ideally, opportunities would be offered for advocates in the aging, domestic violence, and adult protective services sectors to participate in joint training so that each better understands the other's mandates, philosophies, challenges, and professional cultures. To learn more, visit the National Center on Elder Abuse Web site www.elderabusecenter.org.

Services in the Community

Senior Employment and Volunteer Opportunities

Senior employment services are designed to link mature job seekers 55 and over with job opportunities. Income eligible persons are recruited, trained, and referred to job openings with local employers. Funding for the Senior Community Service Employment Program, or SCSEP, comes from the U.S. Department of Labor. SCSEP is operated by national, state, and local agency sponsors. The ultimate goal is to place mature and older workers in permanent, non-subsidized employment. Volunteer opportunities abound in the aging network. Examples include friendly visiting to shut-ins, volunteer ombudsmen service, home meal delivery, benefits counseling, and senior companion services for developmentally disabled children and adults.

SCSEP may be a source of help for older domestic violence victims who need job coaching and a gradual, supportive entry into the world of work. According to AARP, more than one quarter of SCSEP positions are filled by job seekers 55–59. Volunteer opportunities in service to older persons may be particularly important for domestic violence victims who feel isolated and for whom such experience would enhance a sense of independence and self-worth. Volunteer opportunities can be explored through contact with the AAA information and referral/assistance service.

In-Home Supportive and Personal Care Services
A wide range of supporting in home, homemaker, and chore services are available to assist older adults who need help with everyday activities. These services are non-medical and may include such things as light housekeeping, laundry, personal care, shopping and cooking, transportation, friendly visiting and telephone reassurance, respite, repair or yard work, and case management. The AAA provides information and assistance in accessing these services. In-home supportive services help prevent social isolation and may help to reduce the likelihood of elder abuse, neglect, and exploitation by family members.

Senior Centers
There are now thousands of senior community centers around the country. These community gathering places serve a variety of purposes, including functioning as meal sites, screening clinics, recreational centers, social service agency branch offices, mental health counseling clinics, older worker employment agencies, volunteer coordinating centers, and community meeting halls. Senior centers are key locations for reaching victims, or potential victims, of late life domestic violence. They offer a convenient meeting place for community education and discussion/support groups on domestic violence/elder abuse. They can also be a resource for finding community volunteers. Local senior centers offer different types of programs and services based on population needs and resource availability. For more information, contact your local AAA. Working with the Aging Network As with other human service systems, the national aging network is diverse. At the same time, however, members of the network share a common set of values and a single vision: to protect the inherent dignity, security, and equal rights of all older Americans. The key unifying values are these:

➢ **Self-determination**. The value of self-determination is based on a belief that all older Americans, including residents of nursing and care homes, are entitled to plan and manage their own daily lives: where they live, how they spend their money, what services they receive, and other important daily decisions. Respect, active listening, and open communication are essential tools for empowering choice and independence. If a person loses decision-making capacity due to dementia or other mental health need, a legal guardian or surrogate decision-maker may be appointed (by the individual or court) to make decisions in his or her behalf.

➢ **Advocacy**. Uniquely in federal law, Older Americans Act authorizing legislation requires state and area agencies on aging to be "visible and

active advocates" for older persons. In their role as "systems advocates" they speak out on policy issues; testify at federal/state/local hearings; and identify unmet needs and gaps in services. In parallel step, elder rights programs such as long-term care ombudsman and legal assistance serve an individual advocacy role, speaking out for those who are without voice. There may be distinctions in how the aging network and the domestic violence programs view their advocacy roles. This may be a fruitful place to start identifying similarities and distinctions.

➢ **Elder rights**. The term "elder rights" reflects the aging network's belief that older people have a right to the many benefits, services, and protections promised in law—not just aging statutes, but statutes covering the population at large. Older persons' needs are often ignored and access to important services denied. By providing stepped-up information about benefits to help cut through red tape, legal representation to solve problems, and protective services for those who are most vulnerable, the aging network plays a key role in promoting elder rights. Typically, the states' elder rights systems focus on the coordination of adult protective, long term care ombudsman, legal assistance services.

➢ **Community-based long term care.** This term encompasses the effort within the aging network to offer elders with long term care needs health and supportive services in their own homes and community. Homemaker, home-health aide, day care, and personal attendant care are among the services provided. Medicaid waivers fund a large proportion of these services. Caregiver support services (such as respite care) are provided to help families maintain the elder in non-institutional settings.

➢ **Eligibility and fees**. Other than age, there are no eligibility criteria restricting services under the Older Americans Act. Other senior services, especially those funded by special state appropriations and federal Medicaid waivers, may have financial criteria for eligibility, require cost sharing, or be offered on a sliding fee schedule. For many in-home services (home-delivered meals, homemaker and chore services, for example) individual needs assessments establish service priorities. There are waiting lists for many services. Under the Older Americans Act, priority in home and community service delivery is given to those who are determined to be in greatest need.

About the Older Victim: Common Indicators of Domestic Violence in Later Life

New collaborations benefit from dialogue and common understanding. Not surprisingly, the behavioral indicators of late life domestic violence parallel victim/ abuser scenarios found in other forms of domestic violence and are likely well known by domestic violence staff. The chart on the next page, developed by experts in elder abuse, is included here to underline the importance of recognizing potential victim and abuser actions.

Responding to and Working with Older Victims

Ending a relationship is always difficult, particularly when it is a loved one. Most victims of abuse in later life prefer to maintain some type of relationship with their spouse/partner, family member, or caregiver – they simply want the abuse to end. Some older victims will choose to stay with an abuser, often for religious, cultural, generational, or financial reasons. These victims can benefit from support, information, safety planning and strategies to break isolation. Personal values formed by an individual's background, experience, and beliefs also play a role. It is important to respect the victim's values, decisions, and cultural heritage. Some cultural groups may be more willing to report abuse or talk to professionals about family problems than others. Race, culture, or ethnicity may influence body language, eye contact, and expressions of emotion. Generational values are also involved. Many older persons may be uncomfortable talking about personal, private matters with strangers. They may fear younger professionals imposing their own generational values about divorce or women's roles onto them and judging their decisions.

Some tips for establishing rapport are:
- **The Setting.** Establish comfort. Choose a quiet place and face the person directly. Pay attention to lighting; reduce glare from outside sources.
- **The Conversation**. Use respectful and formal terms of address: Mrs., Mr., and so on. Introduce yourself clearly. To help reduce stress, start with a non-threatening topic. Speak calmly and clearly in a normal tone. Avoid jargon.
- **Active Listening.** Show from the start that you accept the person and understand. Listen for meaning. *Restate,* "Let's see if I'm clear about this." *Reflect,* "This seems to be really difficult for you."

V*alidate,* "I appreciate your willingness to talk about such a difficult issue."
• **The Plan**. Engage the victim in deciding what the next steps should be. "Let's explore the options." Reinforce steps that have been taken so far. Recognize that decisions may take time. Don't rush. Slow down to give the victim time to sort out what he or she has heard.

Domestic Violence/Aging Network Collaborations
The aging network and domestic violence programs are natural allies in the fight against violence in all its forms. Examples of collaboration include participation on multidisciplinary teams, involvement in coalitions, joint training, joint referral protocols, public education, and policy development. The National Center on Elder Abuse Promising Practices Database www.elderabusecenter.org/default.cfm?p=toolsresources.cfm contains a listing of several projects around the country that provide services in collaboration with domestic violence programs. These projects may serve as examples for aging network staff seeking to form new partnerships.

The Wisconsin Coalition Against Domestic Violence, National Clearinghouse on Abuse in Later Life also has compiled profiles of several elder specific services that are provided by domestic violence programs. A summary can be viewed at www.ncall.us/docs/NCALL_Directory.pdf

State and National Resources on Late Life Violence

➢ **National Domestic Violence Hotline** 1-800-799-SAFE (7233) or 1-800-787-3224 (TTY) www.ndvh.org/ Help is available to callers 24 hours a day, 365 days a year. Assistance is available in English and Spanish with access to more than 140 languages through interpreter services.

➢ **Domestic Violence and Sexual Assault State Coalitions** work with statewide systems and agencies on behalf of the needs and interests of victims of abuse/assault. Coalitions are membership organizations comprised of local domestic violence and sexual assault agencies and other organizations and individuals dedicated to the elimination of abuse. Most do not provide direct services to victims of abuse. Areas where they can help include: public awareness, professional training, community education, information and referral, resource and materials development, technical assistance, and consultation.

Coalitions also monitor state and national legislation and lobby to support the creation of laws that increase victim safety and support and hold perpetrators accountable. A contact directory of state domestic violence coalitions is available on the U.S. Department of Justice, Office of Violence Against Women Web site at www.usdoj.gov/ovw/state.htm. To locate your state sexual assault coalition, seem www.usdoj.gov/ovw/saresources.htm

➢ **National Center on Elder Abuse,** funded by the U.S. Administration on Aging, is a gateway to a wealth of information on subjects ranging from elder abuse and neglect to financial exploitation, nursing home abuse, and domestic violence in later life. Examples of publications are *Domestic Violence: Older Women Can Be Victims Too and Multidisciplinary Elder Abuse Prevention Teams: A New Generation.* For more information, call (202) 898-2578, e-mail ncea@nasua.org or visit the NCEA Web site at www.elderabusecenter.org

➢ **National Clearinghouse on Abuse in Later Life,** a project of the Wisconsin Coalition Against Domestic Violence, has numerous publications and resources concerning older battered women and sexual assault including. Examples include *Golden Voices:Support Groups for Older Abused Women* and *A National Domestic Abuse in Later Life Resource Directory.* For more information, call (608) 255-0539, e-mail wcadv@wcadv.org or visit the Clearinghouse's Web site at www.ncall.org

➢ **American Bar Association Commission on Law and Aging** has produced a *Resource Packet on Domestic Violence and Sexual Abuse in Later* Life with funding from the Office on Violence Against Women at the U.S. Department of Justice. For more information, call (202) 662- 8690 or e-mail *abanet@abanet.org* or visit *www.abanet.org/aging/resourcepack.pdf*

➢ **Clearinghouse on Abuse and Neglect of the Elderly** is the nation's largest computerized collection of scholarly references and other resources relating to elder abuse, neglect, and exploitation. To search for literature, visit the CANE Web site at http://db.rdms.udel.edu:8080/CANE/index.jsp. To narrow the search, key in

'*domestic violence*' or '*older battered women*.' For more information, call (302) 831-3525 or e-mail CANE-Ud@udel.edu

➢ **National Resource Center on Domestic Violence,** a project of the Pennsylvania Coalition Against Domestic Violence, provides technical assistance, training and information on domestic violence and related issues. For more information, call 1- 800-537-2238, or visit the Center's Web site at www.vawnet.org/index.php

➢ **National Coalition Against Domestic Violence** is a national organization of grassroots shelter and service programs for battered women. It serves as a national information and referral center on domestic violence. For information, technical support, or referral, call (303) 839-1852, e-mail mainoffice@ncadv.org or visit the Coalition's Web site at www.ncadv.org/

➢ **Asian & Pacific Islander Institute on Domestic Violence** serves as a forum for, and clearinghouse on information, research, resources, and critical issues about violence against women in Asian and Pacific Islander communities. For more information, call (415) 954-9988, e-mail apidvinstitute@apiahf.org *or* visit the Institute's Web site at www.apiahf.org/apidvinstitute/default.htm

➢ **Sacred Circle, National Resource Center to End Violence Against Native Women** provides training, consultation, and technical assistance to Indian Nations, tribal organizations, law enforcement agencies, prosecutors, and courts to address the safety needs of Native women who are battered, raped and stalked. It is a project of Cangleska, Inc., which operates a shelter on the Pine Ridge reservation in southwestern South Dakota. For more information, call (605) 341-2050, e-mail scircle@sacred-circle.com or visit the Sacred Circle Web site at www.sacred-circle.com

➢ **Alianza – National Latino Alliance for the Elimination of Domestic Violence** is part of a national effort to address the domestic violence needs and concerns of under-served populations in Latino communities. For more information, call (800) 342-9908 or 1 *-800-342-9908,* e-mail *inquiry@dvalianza.org,* or visit the Alianza Web site at www.dvalianza.org

➢ **Institute on Domestic Violence in the African American Community** is focused on setting an agenda to reduce/eliminate domestic violence in the African American community. For more information, call (612) 624-5357, e-mail *nidvaac@che.umn.edu,* or visit the DV Institute Web site at www.dvinstitute.org

➢ **Institute on Aging, San Francisco Elder Abuse Prevention Program** has worked with local and national organizations to create several publications on late life domestic violence. Titles include: *Domestic Violence and the Elderly: A Cross-Training Curriculum in Elder Abuse and Domestic Violence; Serving the Older Battered Woman: A Conference Planning Guide;* and *Older Battered Women: Integrating Aging and Domestic Violence Services.* For more information, call (715) 750-4188, e-mail, elderabuseprevention@ioaging.org or visit the IOA Web site at www.ioaging.org/programs/eap/eap.html

➢ **American College of Obstetricians and Gynecologists, Division of Women's Health Issues** has produced a variety of materials about domestic violence and older battered women. For more information, call (202) 863-2487, or visit the ACOG Web site at www.acog.org/ departments/dept_web.cfm?recno=17

➢ **Area Agency on Aging, Region One, Phoenix** has produced an educational video, *The Dance,* available in English and Spanish (*Nuestro Baile*), depicting the life of an older battered woman. For more information or to order a copy of the video, call (602) 264-2255 or 1-888-783-7500. Or visit the agency's Web site at www.aaaphx.org/ main/domesticViolence.asp

➢ **American Medical Association** has developed diagnostic and treatment guidelines for physicians on topics of domestic violence and elder abuse. For more information, call (312) 464-5066

➢ **Family Violence Prevention Fund** has a number of helpful publications on domestic violence. For more information, visit the FVPF Web site at http://endabuse.org/

7. Elder Abuse Reporting

Throughout the past three decades, significant progress has been made in increasing awareness of abusive relationships. Nonetheless, child abuse and domestic violence continue to receive more recognition than elder abuse and more attention in both public and medical settings.

Due to the growing number of older Americans, the number of elder abuse cases will increase. The impact of elder abuse as a public health issue will likely grow in the future. Abuse victims have twice as many physician visits compared with the general US population. This of course allows opportunities for detection. Since many elders are isolated, an unexpected visit to the emergency department may be the only opportunity for detection. Emergency physicians are in a unique position to affect diagnosis and management of this vulnerable population.

Elder abuse encompasses a range of behaviors, events, and circumstances. Elder abuse usually consists of repetitive incidences including any act of commission or omission that result in harm or threatened harm to the health and welfare of an older adult.

The *US National Academy of Sciences* defines elder abuse as follows:

- *"Intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended), to a vulnerable elder by a caregiver or other person who stands in a trusted relationship to the elder.*
- *Failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm".*

However, terms may vary among professionals and researchers, and usage is not consistent in the laws of different states. For example, the age at which a person is considered elderly, usually 60 or 65 years, varies. Seven categories

of elder abuse have been described by the *National Center on Elder Abuse (NCEA)* including:

- **Physical abuse** - Any act of violence that causes pain, injury, impairment, or disease, including striking, pushing, force-feeding, and improper use of physical restraints or medication

- **Emotional or psychological abuse** - Conduct that causes mental anguish including threats, verbal or nonverbal insults, isolation, and humiliation. Some legal definitions require identification of at least 10 episodes of this type of behavior within a single year to constitute abuse.

- **Financial or material exploitation** - Misuse of an elderly person's money or assets for personal gain. Acts such as stealing (money, social security checks, possessions) or coercion (changing a will, assuming power of attorney) constitute financial abuse.

- **Neglect** - Failure of a caretaker to provide for the patient's basic needs. As in the previous examples of abuse, neglect can be physical, emotional, or financial. Physical neglect is failure to provide eyeglasses or dentures, preventive health care, safety precautions, or hygiene. Emotional neglect includes failure to provide social stimulation (leaving an older person alone for extended periods). Financial neglect involves failure to use the resources available to restore or maintain the well-being of the aging adult.

- **Sexual abuse** - Nonconsensual intimate contact or exposure or any similar activity when the patient is incapable of giving consent. Family members, friends, institutional employees, and fellow patients can commit sexual abuse.

- **Self-neglect** - Behavior in which seniors compromise their own health and safety, as when an aging adult refuses needed help with various daily activities. When the patient is deemed competent, many ethical questions arise regarding the patient's right of autonomy and the physician's oath of beneficence.

- **Abandonment** - The desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder."

Occurrence

A report from the *National Research Council* suggests that 1-2 million Americans age 65 years or older have been injured, exploited, or otherwise

mistreated. Other studies suggest that 3-10% of elders are abused or neglected.   Several variables contribute to the underestimation of abused elders including fear, shame, guilt, and/or lack of information. A variety of professionals underreport elder abuse due to lack of recognition and awareness of reporting requirements. A significant amount of research excludes specific demographics such as persons unable to respond to a survey, speakers of languages other than English, and persons with mental illness. Studies have shown that only 1 in 6 victims are likely to self-report mistreatment to the appropriate legal authorities.

 Elder physical abuse victims, caregiver neglect, or self-neglect have triple the mortality of those never abused. Proactive detection and intervention by professionals could potentially lead to decreased mortality. Healthcare provider proactivity is essential.

Race
Elder abuse exists throughout all racial, socioeconomic, and religious backgrounds. The *NCEA* found the following racial and ethnic distribution among older persons who had been abused:

- White, non-Hispanic – 66.4%
- Black – 18.7%
- Hispanic – 10%
- Other – 4.9%

Gender
Women are believed to be the most common victims of abuse, perhaps because they report abuse at higher rates or because the severity of injury in women typically is greater than in men. Numerous studies, however, have found no differences based on sex.

Age
By definition, elder abuse occurs in the elderly, although there is no universally accepted definition of when old age begins. Typically, 60 or 65 years is considered the threshold of old age.

The American Medical Association has recommended that health care professionals regularly ask elderly patients about abuse, even when there are no visible signs/symptoms. There is not yet a consensus on what constitutes an appropriate screen or assessment instrument for detecting elder abuse.

Risk factors of elder abuse include:

❖ Shared living situation with abuser, likely due to an increased opportunity for contact

❖ Dementia

❖ Social isolation

❖ Pathologic characteristics of perpetrators such as mental illness and alcohol misuse

It would be helpful for providers to consider these "red flags" while providing services for the elderly. The presence of red flags is an indicator that a more in-depth history and/or assessment are necessary. While evaluating a client for possible elder abuse, the provider may want to consider simple and direct questions which are posed in a nonjudgmental or nonthreatening manner. It is also helpful to interview the patient and caregiver both together and separately to detect disparities offering clues to the diagnosis of abuse. Accurate and objective documentation of the interview is important partially because findings may be entered as evidence in criminal trials or in guardianship hearings. Documentation must be complete, thorough, and legible. It is helpful to quote direct statements made by the client.

Physical
In a systematic summary of the published work on forensic markers of elder abuse with respect to physical findings, there is a paucity of primary data. Most research on clinical findings purported to be common in elder abuse derives from anecdotes, case reports, or small case series.
Although not guided strongly by evidence, a number of clinical findings and observations make elder abuse a strong possibility, including the following:

✓ Several injuries in various stages of evolution
✓ Unexplained injuries
✓ Delay in seeking treatment
✓ Injuries inconsistent with history
✓ Contradictory explanations given by the patient and caregiver
✓ Laboratory findings indicating under dosage or over dosage of medications
✓ Bruises, welts, lacerations, rope marks, burns
✓ Venereal disease or genital infections
✓ Dehydration, malnutrition, decubitus ulcers, poor hygiene
✓ Signs of withdrawal, depression, agitation, or infantile behavior

Causes
Many theories have been developed to explain abusive behavior toward elderly people. Clearly, no single answer exists to explain behavior in an abusive relationship. A number of psychosocial and cultural factors are involved.

Theories of the origin of mistreatment of elders have been divided into 4 major categories, as follows: physical and mental impairment of the patient, caregiver stress, trans-generational violence, and psychopathology in the abuser.

- **Physical and mental impairment of the patient**
    - Recent studies have failed to show direct correlation between patient frailty and abuse, even though it had been assumed that frailty itself was a risk factor for abuse.
    - Physical and mental impairment nevertheless appear to play an indirect role in elder abuse, decreasing seniors' ability to defend themselves or to escape, thus increasing vulnerability.

- **Caregiver stress**
    - This theory suggests that elder abuse is caused by the stress associated with caring for an elderly patient, compounded by stresses from the outside world.
    - The effect of stress factors (e.g., alcohol or drug abuse, potential for injury from falls, incontinence, elderly persons' violent verbal behavior, employment problems, low income on the part of the abuser) may all culminate in caregivers' expressions of anger or antagonism toward the elderly person, resulting in violence.
    - This theory, however, does not explain how individuals in identically stressful situations manage without abusing seniors in their care. Stress should be seen more as a trigger for abuse than as a cause.

- **Trans-generational violence**: This theory asserts that family violence is a learned behavior that is passed down from generation to generation. Thus, the child who was once abused by the parent continues the cycle of violence when both are older.

- **Psychopathology in the abuser**: This theory focuses on a psychological deficiency in the development of the abuser. Drug and alcohol addiction, personality disorders, mental retardation, dementia,

and other conditions can increase the likelihood of elder abuse. In fact, family members with such conditions are most likely to be primary caretakers for elderly relatives because they are the individuals typically at home due to lack of employment.

- **Other risk factors** in abuse are (1) shared living arrangements between the elder person and the abuser, (2) dependence of the abuser on the victim, and (3) social isolation of the elder person.

A mandated reporter must report a known or suspected instance of elder or dependent adult abuse when, in his or her professional capacity, or within the scope of his or her employment, he or she (1) has observed or has knowledge of an incident that reasonably appears to be physical abuse, neglect, financial abuse, abandonment, abduction, or isolation; (2) is told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, neglect, financial abuse, abandonment, abduction, or isolation; or (3) reasonably suspects abuse.

Optional Reports: Mandated reporters may report a known or suspected instance of elder or dependent adult abuse when they have knowledge of or reasonably suspect that a form of elder or dependent adult abuse for which a report is not mandated has been inflicted upon an elder or dependent adult or that the elder or dependent adult's emotional well-being is threatened in any other way.

Definition of Elder: An "elder" is a person who is age 65 years or older. **Definition of Dependent Adult**: a dependent adult is a person, between the ages of 18 years and 64 years, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights.

Mandated reporters, including therapists, are now required to report the following: Known and reasonably suspected physical abuse of an elder or dependent adult. Instances of known and reasonably suspected neglect, financial abuse, abandonment, abduction, and/or isolation of an elder or dependent adult, and any other treatment that results in physical harm, pain, or mental suffering.

As a mandated reporter, a psychotherapist is required to make a report of known or suspected elder or dependent adult abuse when, in his or her professional capacity, or within the scope of his or her employment, he or she has observed or has knowledge of an incident that reasonably appears to be abuse, is told by an elder or dependent adult that he or she has

experienced behavior constituting abuse; and/or reasonably suspects abuse.

Abuse of an elder or dependent adult includes the following categories: Physical abuse, neglect, financial abuse, abandonment, abduction, isolation, and any other form of treatment that results in physical harm, pain, or mental suffering. Mental suffering may consist of fear, confusion, severe depression, agitation, or other serious emotional distress caused by threats, harassment, or other forms of intimidating behavior.

Physical Abuse includes assault, assault with a deadly weapon or with force likely to cause great bodily injury; battery; sexual assault, unreasonable physical restraint; prolonged or continual deprivation of water or food; and the use of physical or chemical restraint for punishment, for a period of time beyond that for which the medication was ordered through instructions from a licensed physician or surgeon caring for the elder or dependent adult, and/or for any purpose not authorized by the elder or dependent adult's physician or surgeon.

Neglect refers to the negligent failure of any person having the care or custody of an elder or dependent adult to exercise that degree of care that a reasonable person in a similar position would provide. Neglect also includes self-neglect, the negligent failure of an elder or dependent adult to provide a reasonable degree of care to himself or herself.

Specific examples of neglect include the failure to assist in personal hygiene or in the provision of food, clothing, or shelter as well as the failure to provide medical care for physical or mental health needs and the failure to prevent malnutrition or dehydration.

Financial Abuse means concealing, taking, or appropriating an elder or dependent adult's property or money to any wrongful use or with the intent to defraud.

Abandonment, desertion or willful abandonment by a person having the care or custody of the elder or dependent adult person under circumstances in which a reasonable person would continue to provide care and custody.

Isolation, deliberately preventing an elder or dependent adult from receiving his or her mail or phone calls, false imprisonment; and/or the physical restraint of an elder or dependent adult for the purpose of preventing him or her from meeting with his or her visitors.

Reports of known or reasonably suspected elder or dependent adult abuse must be filed by telephone immediately or as soon as practically possible. A written report must then be sent within two working days.

Reporters should generally make reports to their county's adult protective agency or a local law enforcement agency. There are two exceptions to this, however: First, if the abuse occurred in a state mental health hospital or state developmental center, the report should be made to designated investigators of the State Department of Mental Health or the State Department of Developmental Services or to the local law enforcement agency. Second, if the abuse occurred in a long-term care facility (other than a state mental hospital or a state developmental center), reports should be made to the local ombudsman or to the local law enforcement agency.

Any person legally required to report elder or dependent adult abuse who knowingly fails to report can be found guilty of a misdemeanor that is punishable by not more than six months in the county jail or a fine not to exceed $1,000 or both imprisonment and a fine. A therapist who fails to make a timely mandated elder or dependent adult abuse report may also face disciplinary action by their governing board and civil action for damages. The law provides that no person required making a report of elder or dependent adult abuse shall be criminally or civilly liable for such a report, as long as it cannot be proven that the report was made falsely.

8. Older Adults, Substance Abuse, and Mental Health

This section addresses substance abuse and gerontology to recommend best practices for identifying, screening, assessing, and treating alcohol and prescription drug abuse.

Alcohol Abuse

Physiological changes, as well as changes in the kinds of responsibilities and activities pursued by older adults, make established criteria for classifying alcohol problems often inadequate for this population.

Abuse of Prescription Drugs

People 65 and older consume more prescribed and over-the-counter medications than any other age group in the United States. Prescription drug misuse and abuse is prevalent among older adults not only because more drugs are prescribed to them but also because, as with alcohol, aging makes the body more vulnerable to drugs' effects.

Figure 3-6: Drug-Alcohol Interactions and Adverse Effects

Figure 3-6 Drug-Alcohol Interactions and Adverse Effects	
Drug	**Adverse Effect With Alcohol**
Acetaminophen	Severe hepatoxicity with therapeutic doses of acetaminophen in chronic alcoholics
Anticoagulants, oral	Decreased anticoagulant effect with chronic alcohol abuse
Antidepressants, tricyclic	Combined central nervous system depression decreases psychomotor performance, especially in the first week of treatment
Aspirin and other nonsteroidal anti-inflammatory drugs	Increased the possibility of gastritis and gastrointestinal hemorrhage
Barbiturates	Increased central nervous system depression (additive effects)
Benzodiazepines	Increased central nervous system depression (additive effects)
Beta-adrenergic blockers	Masked signs of delirium tremens
Bromocriptine	Combined use increases gastrointestinal side effects
Caffeine	Possible further decreased reaction time
Cephalosporins and Chloramphenicol	Disulfiram-like reaction with some cephalosporins and chloramphenicol
Chloral hydrate	Prolonged hypnotic effect and adverse cardiovascular effects

Figure 3-6 Drug-Alcohol Interactions and Adverse Effects	
Cimetidine	Increased central nervous system depressant effect of alcohol
Cycloserine	Increased alcohol effect or convulsions
Digoxin	Decreased digitalis effect
Disulfiram	Abdominal cramps, flushing, vomiting, hypotension, confusion, blurred vision, and psychosis
Guanadrel	Increased sedative effect and orthostatic hypotension
Glutethimide	Additive central nervous system depressant effect
Heparin	Increased bleeding
Hypoglycemics, sulfonylurea	Acutely ingested, alcohol can increase the hypoglycemic effect of sulfonylurea drugs; chronically ingested, it can decrease hypoglycemic effect of these drugs
Tolbutamide, chlorpropamide	Disulfiram-like reaction
Isoniazid	Increased liver toxicity
Ketoconazole, griseofulvin	Disulfiram-like reaction
Lithium	Increased lithium toxicity
Meprobamate	Synergistic central nervous system depression
Methotrexate	Increased hepatic damage in chronic alcoholics
Metronidazole	Disulfiram-like reaction
Nitroglycerin	Possible hypotension
Phenformin	Lactic acidosis (synergism)

Figure 3-6 Drug-Alcohol Interactions and Adverse Effects	
Phenothiazines	Additive central nervous system depressant activity
Phenytoin	Acutely ingested, alcohol can increase the toxicity of phenytoin; chronically ingested, it can decrease the anticonvulsant effect of phenytoin
Quinacrine	Disulfiram-like reaction
Tetracyclines	Decreased effect of doxycycline
Source: Korrapati and Vestal	

Any use of drugs in combination with alcohol carries risk; abuse of these substances raises that risk, and multiple drug abuse raises it even further. For example, chronic alcoholics who use even therapeutic doses of acetaminophen may experience severe hepatoxicity. Alcohol can increase lithium toxicity and enhance central nervous system depression in persons taking tricyclic antidepressants. High doses of benzodiazepines used in conjunction with alcohol or barbiturates can be lethal. The many possible unfavorable reactions between prescription drugs and alcohol are summarized in Figure 3-6.

Sedative/Hypnotics

Aging changes sleep architecture, decreasing the amount of time spent in the deeper levels of sleep (stages three and four) and increasing the number and duration of awakenings during the night. However, these new sleep patterns do not appear to bother most medically healthy older adults who recognize and accept that their sleep will not be as sound or as regular as when they were young. Although benzodiazepines and other sedative/hypnotics can be useful for short-term amelioration of temporary sleep problems, no studies demonstrate their long-term effectiveness beyond 30 continuous nights, and tolerance and dependence develop rapidly.

Identification, Screening, and Assessment

The Consensus Panel recommends that every 60-year-old should be screened for alcohol and prescription drug abuse as part of his or her regular physical examination. However, problems can develop after the screening has been conducted, and concurrent illnesses and other chronic conditions may mask abuse. Although no hard-and-fast rules govern the timing of screening, the Panel recommends screening or re-screening if certain physical symptoms are present or if the older person is undergoing major life changes or transitions. Do not use stigmatizing terms like alcoholic or drug abuser during these encounters.

Instruments

The Panel recommends use of the CAGE Questionnaire and the Michigan Alcohol Screening Test-Geriatric Version (MAST-G) to screen for alcohol use among older adults. The Alcohol Use Disorders Identification Test (AUDIT) is recommended for identifying alcohol problems among older members of ethnic minority groups.

Treatment

The Consensus Panel recommends that the least intensive treatment options be explored first with older substance abusers. These initial approaches, which can function either as pretreatment strategy or treatment itself, are brief intervention, intervention, and motivational counseling. They may be sufficient to address the problem; if not, they can help move a patient toward specialized treatment. The Consensus Panel recommends that every reasonable effort be made to ensure that older substance abusers, including problem drinkers, enter treatment. Brief intervention is the recommended first step, supplemented or followed by intervention and motivational interviewing. Because many older problem drinkers are ashamed about their drinking, intervention strategies need to be non-confrontational and supportive.

Conducting Brief Interventions

A brief intervention is one or more counseling sessions, which may include motivation for change strategies, patient education, assessment and direct feedback, contracting and goal setting, behavioral modification techniques,

and the use of written materials such as self-help manuals. *An older adult-specific brief intervention should include the following steps*:

1. Customized feedback on screening questions relating to drinking patterns and other health habits such as smoking and nutrition.
2. Discussion of types of drinkers in the United States and where the patient's drinking patterns fit into the population norms for his or her age group.
3. Reasons for drinking. This is particularly important because the practitioner needs to understand the role of alcohol in the context of the older patient's life, including coping with loss and loneliness.
4. Consequences of heavier drinking. Some older patients may experience problems in physical, psychological, or social functioning even though they are drinking below cutoff levels.
5. Reasons to cut down or quit drinking. Maintaining independence, physical health, financial security, and mental capacity can be key motivators in this age group.
6. Sensible drinking limits and strategies for cutting down or quitting. Strategies that are useful in this age group include developing social opportunities that do not involve alcohol, getting reacquainted with hobbies and interests from earlier in life, and pursuing volunteer activities, if possible.
7. Drinking agreement in the form of a prescription. Agreed-upon drinking limits that are signed by the patient and the practitioner are particularly effective in changing drinking patterns.
8. Coping with risky situations. Social isolation, boredom, and negative family interactions can present special problems in this age group.
9. Summary of the session.

If the client does not respond to the brief intervention, two other approaches should be considered; Intervention and motivational interviewing.

Intervention

The Panel recommends the following modifications to interventions for older patients. No more than one or two relatives or close associates should be involved along with the health care provider; having too many people present may be emotionally overwhelming or confusing for the older person. Inclusion of grandchildren is discouraged, because many older alcoholics resent their problems being aired in the presence of much younger relatives.

Treatment Approaches

The Panel recommends incorporating the following six features into treatment of the older alcohol dependent:
- ✓ Age-specific group treatment that is supportive and non-confrontational and aims to build or rebuild the patient's self-esteem
- ✓ A focus on coping with depression, loneliness, and loss (e.g., death of a spouse, retirement)
- ✓ A focus on rebuilding the client's social support network
- ✓ A pace and content of treatment appropriate for the older person
- ✓ Staff members who are interested and experienced in working with older adults
- ✓ Linkages with medical services, services for the aging, and institutional settings for referral into and out of treatment, as well as case management.

Building from these six features, the Consensus Panel recommends that treatment programs adhere to the following principles:
- ➢ Treat older people in age-specific settings where feasible
- ➢ Create a culture of respect for older clients
- ➢ Take a broad, holistic approach to treatment that emphasizes age-specific psychological, social, and health problems
- ➢ Keep the treatment program flexible
- ➢ Adapt treatment as needed in response to clients' gender.

To help ensure optimal benefits for older adults, the Consensus Panel recommends that treatment plans weave age-related factors into the contextual framework of the American Society of Addiction Medicine (ASAM) criteria. The Consensus Panel recommends the following general approaches for effective treatment of older adult substance abusers:
- ❖ Cognitive-behavioral approaches
- ❖ Group-based approaches
- ❖ Individual counseling
- ❖ Medical/psychiatric approaches
- ❖ Marital and family involvement/family therapy
- ❖ Case management/community-linked services and outreach.

The Panel recommends that cognitive-behavioral treatment focus on teaching skills necessary for rebuilding the social support network; self-

management approaches for overcoming depression, grief, or loneliness; and general problem solving.

Barriers to Identifying and Treating Older Adults with Substance Abuse Problems

The sheer number and the interconnectedness of older adults' physical and mental health problems make diagnosis and treatment of their substance abuse more complex than for other populations. That complexity contributes, directly or indirectly, to the following barriers to effective treatment:

- ✦ Ageism
- ✦ Lack of awareness
- ✦ Clinician behavior
- ✦ Co-morbidity

Screening for Alcohol and Prescription Drug Abuse Barriers to Screening

False assumptions, failure to recognize symptoms, and lack of knowledge about screening are among the barriers that inhibit family members, service providers, and others concerned about older adults from raising the issue of alcohol and prescription drug abuse. Although these are the two primary substances of abuse now, providers are likely to see more marijuana and other drug use among adults over 60 in the coming years. Health care providers sometimes share the ageist attitudes. They may not be trained to recognize signs of substance abuse and furthermore may be unwilling to listen attentively to older patients. The latter type of provider often dismisses older patients' observations about their own symptoms and attempts at self-diagnosis and attributes all complaints or changes in health status to the aging process.

Family members also can impede problem recognition. Biases persist against perceiving older adults as alcoholics or recognizing that drinking or prescription drugs, rather than age or disease, may be a cause or chief contributor to sleep problems, mood changes, or memory deficits *(Finlayson)*. Another assumption inhibiting identification is the belief that older adults do not respond to treatment, a misperception flatly contradicted by studies showing that older adults are more likely to complete treatment *(Linn; Cartensen et. al)* and have outcomes that are as good as or better than those of younger patients when treated as outpatients *(Atkinson)*.

Who and When to Screen

It is preferable to use standardized screening questionnaires, but friendly visitors, Meals-On-Wheels volunteers, caretakers, and health care providers also can interject screening questions into their normal conversations with older, homebound adults. Comfort with this line of questioning will depend on the person's relationship with the older person and the responses given; however, anyone who is concerned about an older adult's drinking practices can try asking direct questions, such as

➢ "Do you ever drink alcohol?"
➢ "How much do you drink when you do drink?"
➢ "Do you ever drink more than four drinks on one occasion?"
➢ "Do you ever drink and drive?"
➢ "Do you ever drink when you're lonely or upset?"
➢ "Does drinking help you feel better [or get to sleep more easily, etc.]? How do you feel the day after you have stopped drinking?"
➢ "Have you ever wondered whether your drinking interferes with your health or any other aspects of your life in any way?"
➢ "Where and with whom do you typically drink?" (Drinking at home alone signals at-risk or potentially abusive drinking.)
➢ "How do you typically feel just before your first drink on a drinking day?"
➢ "Typically, what is it that you expect when you think about having a drink?" (Note: Positive expectations or consequences of alcohol use in the presence of negative affect and inadequate coping skills have been associated with problem drinking.)

If less direct questioning seems appropriate, other useful questions for identifying problematic alcohol or prescription drug use include:
➢ "Are you having any medical or health problems? What symptoms do you have? What do you think these mean? Have you felt this way before?"
➢ "Do you see a doctor or other health care provider regularly? When was the last time? Do you see more than one? Why? Have you switched doctors recently? Why?"
➢ "Have you experienced any negative or unwanted events that altered the way you lived (in the last 5 years)? Any since we last met? How much of an impact did the event have on the way you lived or felt? What feelings or beliefs did it cause or change? Do you believe that you are coping with the changes in a healthy fashion? How

(specifically) do you manage (control) the circumstances (consequences) of the problem(s) or event(s)?"

➤ "What prescription drugs are you taking? Are you having any problems with them? May I see them?" (This question will need to be followed by an examination of the actual containers to ascertain the drug name, prescribed dose, expiration date, prescribing physician, and pharmacy that filled each prescription. Note whether there are any psychoactive medications. Ask the patient to bring the drugs in their original containers.)

➤ "Where do you get prescriptions filled? Do you go to more than one pharmacy? Do you receive and follow instructions from your doctor or pharmacist for taking the prescriptions? May I see them? Do you know whether any of these medicines can interact with alcohol or your other prescriptions to cause problems?"

➤ "Do you use any over-the-counter drugs (nonprescription medications)? If so, what, why, how much, how often, and how long have you been taking them?"

Figure 4-3: The CAGE Questionnaire

Figure 4-3 The CAGE Questionnaire

1. Have you ever felt you should cut down on your drinking?
2. Have people annoyed you by criticizing your drinking?
3. Have you ever felt bad or guilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?

Scoring: Item responses on the CAGE are scored 0 for "no" and 1 for "yes" answers, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant. *Source: Ewing*

Non-medical caretakers, volunteers, and aides may opt to ask only the four CAGE questions, reproduced in <u>Figure 4-3</u> and discussed in the Screening Instruments section. If the older adult answers yes to any of the four, refer to a clinician for evaluation. If the questioner suspects that prescription drug abuse may be occurring and the older adult is defensive about his or her use, confused about various prescription drugs, seeing more than one doctor, or using more than one pharmacy, a clinician should probably be notified to probe further. Other warning signs that may emerge in conversation and should prompt a more in-depth screen or an assessment include

❖ Excessively worrying about whether prescription psychoactive drugs are "really working" to alleviate numerous physical complaints; complaints that the drug prescribed has lost its effectiveness over time (evidence of tolerance)

❖ Displaying detailed knowledge about a specific psychoactive drug and attaching great significance to its efficacy and personal impact

❖ Worrying about having enough pills or whether it is time to take them to the extent that other activities revolve around the dosage schedule

❖ Continuing to use and to request refills when the physical or psychological condition for which the drug was originally prescribed has or should have improved (e.g., prescription of sleeping pills after the death of a loved one); resisting cessation or decreasing doses of a prescribed psychoactive drug

❖ Complaining about doctors who refuse to write prescriptions for preferred drugs, who taper dosages, or who don't take symptoms seriously

❖ Self-medicating by increasing doses of prescribed psychoactive drugs that aren't "helping anymore" or supplementing prescribed drugs with over-the-counter medications of a similar type

❖ Rating social events by the amount of alcohol dispensed

❖ Eating only at restaurants that serve alcoholic beverages (and wanting to know whether they do in advance)

❖ Withdrawing from family, friends, and neighbors

❖ Withdrawing from normal and life-long social practices

❖ Cigarette smoking

❖ Involvement in minor traffic accidents (police do not typically suspect older adults of alcohol abuse and may not subject them to Breathalyzer and other tests for sobriety)

❖ Sleeping during the day

❖ Bruises, burns, fractures, or other trauma, particularly if the individual does not remember how and when they were acquired

- ❖ Drinking before going to a social event to "get started"; gulping drinks, guarding the supply of alcoholic beverages, or insisting on mixing own drinks
- ❖ Changes in personal grooming and hygiene
- ❖ Expulsion from housing
- ❖ Empty liquor, wine, or beer bottles or cans in the garbage or concealed under the bed, in the closet, or in other locations.

Asking Screening Questions

Screening questions should be asked in a confidential setting and in a nonthreatening, nonjudgmental manner. Many older adults are acutely sensitive to the stigma associated with alcohol and drug abuse and are far more willing to accept a "medical" as opposed to a "psychological" or "mental health" diagnosis as an explanation for their problems. Prefacing questions with a link to a medical condition can make them more palatable. For example, "I'm wondering if alcohol may be the reason why your diabetes isn't responding as it should," or, "Sometimes one prescription drug can affect how well another medication is working. Let's go over the drugs you're taking and see if we can figure this problem out." It is vitally important to avoid using stigmatizing terms like *alcoholic* or *drug abuser* during these encounters.

Another technique that may help when talking with older adults is active listening. The four components of active listening are:
1. Observing and reading the person's nonverbal behavior - posture, facial expressions, movement, and tone of voice;
2. Listening to and understanding the person's verbal communication;
3. Listening in context, that is, to the whole person in the context of the social settings of his or her life;
4. Listening to sour notes, that is, things the person says that may have to be challenged. Motivational interviewing techniques also can be applied when screening older adults. Essentially this approach assumes that the patient is both capable of and responsible for initiating needed changes. Motivational interviewing is non-confrontational, egalitarian, and supportive.

When screening anyone, especially older adults, empathy is crucial. However, in attempting to be non-confrontational and circumspect, it is also important to avoid using euphemisms that minimize the problem. Older adults with alcohol and prescription drug problems are just as likely to

engage in denial and rationalization as younger adults; those who are inadvertently misusing a prescription drug or who are unaware that their customary drink before dinner may now be causing problems are unlikely to be defensive about acknowledging the need to change.

Figure 4-4 Michigan Alcoholism Screening Test - Geriatric Version (MAST-G)		
1. After drinking have you ever noticed an increase in your heart rate or beating in your chest?	YES	NO
2. When talking with others, do you ever underestimate how much you actually drink?	YES	NO
3. Does alcohol make you sleepy so that you often fall asleep in your chair?	YES	NO
4. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?	YES	NO
5. Does having a few drinks help decrease your shakiness or tremors?	YES	NO
6. Does alcohol sometimes make it hard for you to remember parts of the day or night?	YES	NO
7. Do you have rules for yourself that you won't drink before a certain time of the day?	YES	NO
8. Have you lost interest in hobbies or activities you used to enjoy?	YES	NO
9. When you wake up in the morning, do you ever have trouble remembering part of the night before?	YES	NO
10. Does having a drink help you sleep?	YES	NO
11. Do you hide your alcohol bottles from family members?	YES	NO
12. After a social gathering, have you ever felt embarrassed because you drank too much?	YES	NO

Figure 4-4 Michigan Alcoholism Screening Test - Geriatric Version (MAST-G)		
13. Have you ever been concerned that drinking might be harmful to your health?	YES	NO
14. Do you like to end an evening with a nightcap?	YES	NO
15. Did you find your drinking increased after someone close to you died?	YES	NO
16. In general, would you prefer to have a few drinks at home rather than go out to social events?	YES	NO
17. Are you drinking more now than in the past?	YES	NO
18. Do you usually take a drink to relax or calm your nerves?	YES	NO
19. Do you drink to take your mind off your problems?	YES	NO
20. Have you ever increased your drinking after experiencing a loss in your life?	YES	NO
21. Do you sometimes drive when you have had too much to drink?	YES	NO
22. Has a doctor or nurse ever said they were worried or concerned about your drinking?	YES	NO
23. Have you ever made rules to manage your drinking?	YES	NO
24. When you feel lonely, does having a drink help?	YES	NO
Scoring: Five or more "yes" responses are indicative of an alcohol problem. For further information, contact Frederic C. Blow, Ph.D., at University of Michigan Alcohol Research Center, 400 E. Eisenhower Parkway, Suite A, Ann Arbor, MI 48108; (734) 998-7952. *Source:* Blow, F.C.; Brower, K.J.; Schulenberg, J.E.; Demo-Dananberg, L.M.;		

The MAST-G was developed specifically for older adults (see Figure 4-4) and has high sensitivity and specificity among older adults recruited from a wide range of settings, including primary care clinics, nursing homes, and older adult congregate housing locations.

Before discussing results with an older adult, clinicians must be prepared with information about community resources available to assist in coping with this problem (e.g., meeting dates, times, and locations of Alcoholics Anonymous and other self-help recovery groups whose membership is

largely 55 and older; contact and eligibility information for treatment programs that respond to the special needs of older adults); the older adult's available supports (e.g., Is transportation available? Is the recommended program affordable or covered by insurance?); and the older adult's special needs (e.g., Is the program bilingual or wheelchair accessible?). In addition, a strategy for responding to denial or refusal to follow through with a plan of action should be in place. With the agreement of an older adult involved in a self-help group or treatment program, clinicians can broker an introduction to a peer "who's been there." Frequently, these "veterans" will accompany prospective members to meetings and mentor them through the treatment process.

For some older adults coming to grips with an alcohol or prescription drug problem, repeated contacts will be necessary before they are willing to cooperate with a referral. Clinicians have observed that this process is akin to planting and nurturing a seed. Bringing the seed to fruition, however, ultimately depends on the older adult. Scoring: Five or more "yes" responses are indicative of an alcohol problem.

Assessing Co-Morbid Disorders

The relationship between alcohol use and a coexisting physical or mental disorder can take many different forms. At one extreme, medical and psychiatric problems can coexist with alcohol use with no specific relationship to drinking. Alternatively, those problems may be precipitating or maintenance factors for drinking. The use of alcohol to anesthetize pain is an example of a maintenance factor; alcohol use can then become its own problem or cause drug interaction problems with prescribed pain medications. Medical or psychiatric problems such as alcoholic cirrhosis or cognitive deficits are other possible consequences of drinking. Even when the link is not so direct, alcohol use can worsen other conditions such as hypertension or congestive heart failure.

The existence of co-morbid medical and psychiatric disorders will influence treatment choice and priorities and will affect treatment outcome. Frail or medically compromised alcohol abusers, for example, may require more intensive monitoring during the detoxification period of treatment than their more robust peers. When disorders such as uncontrolled hypertension or depression are detected, reducing alcohol consumption becomes a priority; until drinking is curbed, medication prescribed for those conditions will not

work effectively. In contrast, for older adults suffering from chronic pain, the priority would be to identify an effective painkiller, then taper the amount of alcohol consumed.

Psychiatric Co-Morbidities
Data from the Epidemiologic Catchment Area (ECA) study have strengthened support for a possible link between alcohol use and abuse and the development of other psychiatric illnesses (*Regier et al.*). Adults with a lifetime diagnosis of alcohol abuse or dependence had nearly three times the risk of being diagnosed with another mental disorder. Co-morbid disorders associated with alcohol use include anxiety disorders, affective illness, cognitive impairment, schizophrenia, and antisocial personality disorder. According to one study, older alcohol abusers are more likely to have triple diagnoses alcohol, depression, and personality disorders whereas younger substance abusers are more likely to have diagnoses of schizophrenia (*Speer and Bates*).

Cognitive Impairments

Figure 4-5: Comparison of Dementia and Delirium: Characteristics and Cause

Figure 4-5 Comparison of Dementia and Delirium: Characteristics and Causes	
Dementia	**Delirium**
Impairments in short- and long-term memory, abstract thinking, and judgment	Inability to appreciate and respond normally to the environment, often with altered awareness, disorientation, inability to process visual and auditory stimuli, and other signs of cognitive dysfunction
✓ Aphasia (language disorder)	✓ Potentially life-threatening
✓ Apraxia (inability to carry out motor activities despite intact comprehension and motor function)	✓ Acute onset ✓ Clouding of consciousness
✓ Agnosia (inability to recognize or identify items despite intact sensory function)	✓ Reduced wakefulness ✓ Disorientation to time and space ✓ Increased motor activity (e.g., restlessness, plucking, picking)
✓ Constructional difficulty (inability to copy three-dimensional figures, assemble blocks, or arrange sticks in specific designs)	✓ Impaired attention and concentration ✓ Impaired memory ✓ Anxiety, suspicion, and agitation ✓ Variability of symptoms over time
✓ Personality change or alteration and accentuation of premorbid traits	✓ Misinterpretation, illusions, or hallucinations
✓ Mood disturbances ✓ Loss of self-care abilities	✓ Disrupted thinking, delusions, speech abnormalities

Figure 4-5 Comparison of Dementia and Delirium: Characteristics and Causes

Causes	**Most Common Causes** ➢ Alzheimer's disease ➢ Vascular dementia ➢ Alcohol-related dementia **Common Metabolic/Toxic Causes** ➢ Chronic drug-alcohol-nutritional abuse (e.g., Wernicke-Korsakoff syndrome) ➢ Organ system failure ➢ Anoxia ➢ Folic acid deficiency ➢ Hypothyroidism ➢ Bromide intoxication ➢ Hypoglycemia **Common Infectious Causes** ➢ Neurosyphilis paresis (a syphilitic infection manifested as dementia, seizures, and problems walking and standing) ➢ AIDS/HIV-related disorders ➢ Meningitis ➢ Encephalitis	**Common Intracranial Causes** ➢ Infections (e.g., meningitis, encephalitis) ➢ Seizures ➢ Stroke ➢ Subdural hematomas ➢ Tumors **Common Extracranial Causes** ➢ Anesthesia ➢ Drug-drug or alcohol-drug interactions ➢ Intoxication and/or withdrawal from alcohol or drugs (particularly psychoactive drugs) ➢ Toxic effects of prescribed or over-the-counter drugs ➢ Giant cell arteritis (a chronic inflammatory process involving the extracranial arteries) ➢ Hip fracture ➢ Hydrocephalus (increased fluid in the brain) ➢ Hypercapnia (reduced ventilation often associated with chronic obstructive pulmonary disease) ➢ Infections ➢ Dehydration ➢ Malnutrition ➢ Metabolic disturbances (e.g.,

Affective Disorders

Affective disorders, common in older patients, also influence treatment choices. For example, a patient with an affective disorder who takes psychotropic drugs requires a treatment program with a staff familiar with these medications. Suicidal patients require intensive inpatient programs and an immediate intervention. Significant depressive symptoms, which are a common reaction after detoxification, can be worse in older adults than in younger patients and may require prescribed medicines to alleviate the depression before the abuse or addiction therapy is resumed.

Other Psychiatric Disorders

There are other psychiatric disorders (e.g., schizophrenia, obsessive and compulsive behaviors) that complicate the treatment of abuse and addiction. In these instances, treatment options must be evaluated on a case-by-case basis, although all programs considered for referral should include medical and mental health personnel skilled in responding to those disorders. Although suicide is not a specific psychiatric disorder, the Panel believes that there is a significant relationship among aging, alcohol use, and suicide. People older than 65 account for 25 percent of the national suicide rate (*Conwell*). Patients who attempt suicide require immediate and intensive inpatient therapy for as long as the illness persists. Providers must be alert to the possibility of major depression, which is common in older adults, evolving into suicidal tendencies. It helps if family and significant others, clergy, social workers, and home health care providers are knowledgeable about the warning signs for suicide, because these symptoms are more frequently manifested in nonclinical settings.

Moving the Older Adult into Treatment

After determining that an older adult may benefit from a reduction in or complete abstention from alcohol use, the clinician must next assess the patient's understanding of this benefit. Many older adults may not know that their alcohol use is affecting their health. Because patient understanding and cooperation are essential both in eliciting accurate information and following through on the treatment plan prescribed, clinicians should use the assessment process as an opportunity to educate the older adult and to motivate him or her to accept treatment.

Interacting with Older Adults

Many health care professionals rarely interact with older adults. To facilitate the assessment process with this population, the Consensus Panel recommends that clinicians adhere to the following guiding principles:

- ❖ Areas of concern most likely to motivate older substance abusers are their physical health, the loss of independence and function, financial security, and maintenance of independence.
- ❖ Assessment and treatment decisions must include the patient in order to be successful. This is particularly relevant for older adults, who may be very uncomfortable in formalized addiction treatment programs that do not include many of their peers or address their specific developmental and health needs.
- ❖ Depending on an individual's particular situation, it may be important to include family members in treatment or intervention discussions (understanding that children may vacillate between a desire to help and denial and that patient confidentiality must always be respected).
- ❖ Addiction is a chronic illness that ebbs and flows. Thus, patients' needs will change over time and will require different types and intensities of treatment.
- ❖ Because many older adults have several health care providers (e.g., visiting nurses, social workers, adult day care staff, religious personnel), it is important to include this network as a resource in assessment and in providing treatment.
- ❖ Given the complex health needs of older adults, health care providers may need assistance from experienced non-medical personnel to adequately assess the totality of treatment issues and choices. Providers should be aware of their limitations both in providing addiction treatment and in assessing and treating mental or physical health needs.
- ❖ All treatment strategies must be culturally competent and, to the extent possible, incorporate appropriate ethnic considerations (e.g., rituals).
- ❖ Overarching continuity of care issues and considerations should be identified and addressed, especially in rural and minority communities where emergency room staff function as primary care providers.

Referral and Treatment Approaches

Once screening and assessment have identified a problem, the clinician and patient must choose the most appropriate treatment. The Consensus Panel recommends that the least intensive treatment options be explored first: brief intervention, intervention, and motivational counseling. Although these three approaches can be sufficient to address the problem for some older patients, for others they will function as pretreatment strategies. These less intensive options will not resolve the latter type of patients' alcohol or other drug problems but can move them into specialized treatment by helping them overcome resistance to and ambivalence about changing their drinking behavior.

Like treatment itself, pretreatment activities in some cases may be conducted best in the client's home and can be coupled with other personal or social services (*Fredriksen, Graham et al.*) or with home-based detoxification services (*Cooper*). This approach is ideal for the large number of at-risk older individuals who are homebound; it can be conducted by visiting nurses, housing authorities, and social workers. Community health services often have staff designated to make visits to older adults in their homes, and some in-home treatment programs have a visiting nurse who identifies and treats substance abuse in the home.

Least Intensive Options

Brief Intervention for At-risk Drinkers
Research has shown that 10 to 30 percent of nondependent problem drinkers reduce their drinking to moderate levels following a brief intervention by a physician or other clinician. A brief intervention is one or more counseling sessions, which may include motivation-for-change strategies, patient education, assessment and direct feedback, contracting and goal setting, behavioral modification techniques, and the use of written materials such as self-help manuals (*Fleming et al.*). Brief intervention techniques have been used to reduce alcohol use in adolescents, in adults under age 65 who are nondependent problem drinkers, and most recently, in older adults (*Blow, in press; Fleming et al.*). All of these activities can be conducted by trained clinicians, home health care workers, psychologists, social workers, and professional counselors (e.g., physicians, nurses, physicians' assistants).

Brief intervention strategies range from relatively unstructured counseling and feedback to more formal structured therapy and rely heavily on concepts and techniques from the motivational psychology and behavioral self-control training literature (*Miller and Taylor, Miller and Hester, Miller and Munoz, Miller and Rollnick*). The goal is to motivate the problem drinker to change his behavior, not to assign blame. Drinking goals accordingly should be flexible, allowing the individual to choose drinking in moderation or abstinence.

Conducting Brief Interventions with Older Adults
Older adults present unique challenges to those applying brief intervention strategies for reducing alcohol consumption. Because many older at-risk and problem drinkers are ashamed about their drinking, intervention strategies need to be especially non-confrontational and supportive. In addition, the consumption level that constitutes at-risk drinking is lower than that for younger individuals (*Chermack et al.*), so even low levels can be dangerous. Chronic medical conditions may make it more difficult for clinicians to recognize the role of alcohol in decreases in functioning and quality of life. These issues must be kept in mind during brief interventions with this vulnerable population.

One approach devised to facilitate brief interventions is known by the acronym *FRAMES*. This approach emphasizes
- ✓ **Feedback** of personal risk or impairment as derived from the assessment
- ✓ Personal **responsibility** for change
- ✓ Clear **advice** to change
- ✓ A **menu** of change options to increase the likelihood that an individual will find a responsive treatment (although multiple attempts may be necessary)
- ✓ An **empathic** counseling style
- ✓ Enhanced client **self-efficacy** and ongoing follow up (*Miller and Sanchez*).

Panel members agree that when older adults are motivated to take action on their own behalf, the prognosis for positive change is extremely favorable. Key to inspiring motivation is the clinician's caring style, willingness to view the older adult as a full partner in his or her recovery, and capacity to provide hope and encouragement as the older adult progresses through the referral, treatment, and recovery process.

Intervention and Motivational Counseling

If the older problem drinker does not respond to the brief intervention, two other approaches, intervention and motivational counseling , should be considered.

Intervention

In an intervention, which occurs under the guidance of a skilled counselor, several significant people in the client's life confront the individual with their firsthand experiences of his or her drinking or drug use (*Johnson, Twerski*). The formalized process begins before the intervention and includes a progressive interaction between the counselor and the family or friends for at least 2 days before meeting with the patient. During this time, the counselor not only helps plan the intervention but also educates the family about substance abuse and its prevention (*Johnson*). Participants are coached about offering information in an emotionally neutral, factual manner while maintaining a supportive, non-accusatory tone, thus presenting incontrovertible evidence to the loved one that a problem exists. When using this approach with older adults, Panel members recommend some modifications. No more than one or two relatives or close associates should be involved along with the counselor; having too many people present may be emotionally overwhelming or confusing for the older person. The most influential person to include in interventions or any other pretreatment activity may be a spouse, cohabitant, care giving son or daughter, clergy member, or visiting nurse or caseworker, depending on the particular social network of the client. Inclusion of grandchildren is discouraged: Panel members report that many older alcoholics describe long-lasting resentment and shame about the airing of their problems in the presence of much younger relatives.

Because denial is as much a part of psychoactive prescription drug dependence as it is of alcoholism and addiction to illicit drugs, an intervention may help move psychoactive drug abusers toward detoxification or other formal treatment, although extra caution is advisable. Both the diagnosis of abuse or dependence and the need for treatment are particularly difficult for older patients to accept because their initial use of psychoactive prescription drugs was, in almost all cases, originally sanctioned by a health care provider and prescribed as a remedy for a

legitimate medical problem or complaint. As a group, older adults tend to have even greater disdain for "drug addicts" than the general population: Any implied linkage with the criminalized population of illicit drug users is unnecessarily stigmatizing and appropriately resented. Such labels as *addict, alcoholic,* and *drunkard* should be avoided.

Figure 5-1: ASAM-PPC-2 Assessment Dimensions

Figure 5-1 ASAM-PPC-2 Assessment Dimensions
Dimension 1 - Acute Intoxication and/or Withdrawal Potential
What risk is associated with the patient's current level of acute intoxication? Is there significant risk of severe withdrawal symptoms or seizures, based on the patient's previous withdrawal history, amount, frequency, and recency of discontinuation or significant reduction of alcohol or other drug use? Are there current signs of withdrawal? Does the patient have supports to assist in ambulatory detoxification, if medically safe?
Dimension 2 - Biomedical Conditions and Complications
Are there current physical illnesses, other than withdrawal, that need to be addressed or that may complicate treatment? Are there chronic conditions that affect treatment?
Dimension 3 - Emotional/Behavioral Conditions and Complications
Are there current psychiatric illnesses or psychological, behavioral, or emotional problems that need to be addressed or which complicate treatment? Are there chronic conditions that affect treatment? Do any emotional/behavioral problems appear to be an expected part of addiction illness, or do they appear to be autonomous? Even if connected to the addiction, are they severe enough to warrant specific mental health treatment?
Dimension 4 - Treatment Acceptance/Resistance

Figure 5-1 ASAM-PPC-2 Assessment Dimensions
Is the patient actively objecting to treatment? Does the patient feel coerced into treatment? How ready is the patient to change? If willing to accept treatment, how strongly does the patient disagree with others' perceptions that he or she has an addiction problem? Does the patient appear to be compliant only to avoid a negative consequence, or does he or she appear to be internally distressed in a self-motivated way about his or her alcohol/other drug use problems?
Dimension 5 - Relapse/Continued Use Potential
Is the patient in immediate danger of continued severe distress and drinking/drug-taking behavior? Does the patient have any recognition of, understanding of, or skills with which to cope with his or her addiction problems in order to prevent relapse or continued use? What severity of problems and further distress will potentially continue or reappear if the patient is not successfully engaged in treatment at this time? How aware is the patient of relapse triggers, ways to cope with cravings to use, and skills to control impulses to use?
Dimension 6 - Recovery Environment
Are there any dangerous family members, significant others, living situations, or school/working situations that pose a threat to treatment engagement and success? Does the patient have supportive friendships, financial resources, or education/ vocational resources that can increase the likelihood of successful treatment? Are there legal, vocational, social service agency, or criminal justice mandates that may enhance the patient's motivation for engagement in treatment?
Source: *American Society of Addiction Medicine.*

The answers to these questions should help the provider assess the severity of the problem and the intensity of the services required. For older adults, the triage process is often greatly influenced by factors other than the severity of a drinking or prescription drug problem. For example, physical accessibility of facilities will influence treatment choices for wheelchair-bound patients; hearing-impaired patients will need programs with individual therapy and/or modified small group therapy.

Language barriers, illiteracy, and different cultural views of and customs surrounding substance abuse add to the complex of factors required to assess functional abilities in older adult patients. To help ensure optimal benefits for older adults, the Consensus Panel recommends that treatment plans weave age-related factors into the contextual framework of the ASAM criteria.

Levels of Treatment Services

The following section provides an overview of treatment services from the most to the least intensive, with examples demonstrating how various circumstances may affect the level of care at which a service is offered.

Inpatient/Outpatient Detoxification Treatment

One of the first issues to consider for an older patient with a substance dependence diagnosis is whether detoxification management is necessary and, if so, whether it should be undertaken in an inpatient hospital-based setting or managed on an outpatient basis. No studies or reports specifically assess the potential risks or benefits of outpatient detoxification among older adults, but detoxification is generally seen as medically riskier for an older person. Until more research is available, best clinical judgment must guide such decisions. For more information on detoxification, see TIP 19, Detoxification from Alcohol and Other Drugs (*CSAT*). Medical safety and potential access to the abused drugs are primary considerations when deciding whether an older patient's withdrawal from prescription drugs requires supervision in a hospital. Factors indicating the need for inpatient detoxification include

- ✓ A high potential for developing dangerous abstinence symptoms such as a seizure or delirium because (1) the dosage of alcohol or drug has been particularly high or prolonged and has been discontinued abruptly or (2) the patient has experienced these serious symptoms at any time previously
- ✓ Suicidal ideation or threats
- ✓ The presence of other major psychopathology
- ✓ Unstable or uncontrolled co-morbid medical conditions requiring 24-hour care or parenterally administered medications (e.g., renal disease, diabetes)
- ✓ Mixed addictions, (e.g., alcohol, sedative/hypnotic drugs)

✓ A lack of social supports at home or living alone with continued access to the abused substance(s)
✓ A failure to respond to outpatient treatment.

Treatment Approaches

The Consensus Panel recommends the following general approaches for effective treatment of older adult substance abusers:
❖ Cognitive-behavioral approaches
❖ Group-based approaches
❖ Individual counseling
❖ Medical/psychiatric approaches
❖ Marital and family involvement/family therapy
❖ Case management/community-linked services and outreach.

Not every approach will be necessary for every client. Instead, the program leaders can individualize treatment by choosing from this menu to meet the needs of the particular client. Planning information comes from interviews; mental status examinations; physical examinations; laboratory, radiological, and psychometric tests; and social network assessments, among others.

Figure 5-3: Treatment Objectives and Approaches

Figure 5-3 Treatment Objectives and Approaches	
General Objectives/ Examples	**General Approaches/Examples**
Eliminate or reduce substance abuse	Cognitive-behavioral (group or individual) ✓ Alcohol (drug) effects ✓ Relapse prevention ✓ Stress management Group approaches ✓ Alcohol (drug) effects education Medical ✓ Naltrexone, acamprosate (alcohol)

Figure 5-3 Treatment Objectives and Approaches	
Safely manage intoxication episodes during treatment	Medical ✓ Remove patient from activities and observe ✓ Link and refer to detoxification program
Enhance relationships	Cognitive-behavioral (group or individual) ✓ Social skills and network building Group approaches ✓ Social support ✓ Socialization skill education ✓ Gender-specific issues Marital and family approaches ✓ Spouse counseling ✓ Marital therapy ✓ Family therapy Case management ✓ Linkage to community social programs ✓ Home visitation Individual counseling ✓ Focus on psychodynamic issues in relationships
Promote health ✓ Improve sleep habits ✓ Improve nutrition ✓ Increase exercise ✓ Reduce tobacco use ✓ Reduce stress	Medical ✓ Provide primary medical care Cognitive-behavioral (group or individual) ✓ Self-management skills training Group approaches ✓ Health education ✓ Education on nutrition, diet, cooking, shopping ✓ Sleep hygiene

Figure 5-3 Treatment Objectives and Approaches	

Stabilize and resolve comorbidities
✓ Medical
✓ Psychiatric (e.g., depression, anxiety)
✓ Sensory deficits
	Medical
	  ✓ Consultation and special assessments, including medication assessment
	  ✓ Primary and specialized medical care
	  ✓ Psychiatric care for chronic mental disorders (by geriatric psychiatrist, if possible)
	  ✓ Pain management for chronic pain disorders
	  ✓ Antidepressants, antianxiety medication
	Cognitive-behavioral (group or individual)
	  ✓ Relaxation training
	  ✓ Depression

Cognitive-Behavioral Approaches

There are three broad categories of cognitive-behavioral approaches: behavior modification/therapy, self-management techniques, and cognitive-behavioral therapies. Behavior modification applies learning and conditioning principles to modifying overt behaviors - those behaviors obvious to everyone around the client (*Powers and Osborne, Spiegler and Guevremont*). Self-management refers to teaching the client to modify his or her overt behaviors as well as internal or covert patterns. Cognitive-behavior modification involves altering covert patterns or behaviors that only the client can observe. Cognitive-behavioral techniques teach clients to identify and modify self-defeating thoughts and beliefs (*Dobson, Scott et al.*). The cognitive-behavioral model offers an especially powerful method for targeting problems or treatment objectives that affect drinking behavior. Together, provider and client analyze the behavior itself, constructing a "drinking behavior chain." The chain is composed of the antecedent situations, thoughts, feelings, drinking cues, and urges that precede and initiate alcohol or drug use; the drinking or substance-abusing behavior (e.g., pattern, style); and the positive and negative consequences of use for a given individual. When exploring the latter, it is particularly important to note the *positive* consequences of use: those that maintain abusive behavior.

Researchers have developed an instrument that can elicit by interview the individual's drinking or drug use behavior chain (*Dupree and Schonfeld*). Immediate antecedents to drinking include feelings such as anger, frustration, tension, anxiety, loneliness, boredom, sadness, and depression. Circumstances and high-risk situations triggering these feelings might include marital or family conflict, physical distress, or unsafe housing arrangements, among others. Many older adults drink excessively in response to perceived losses and changes associated with aging and their affective and behavioral response to those losses. Alcohol use is often a form of "self-medication," a means to soften the impact of unwanted change and feelings. For the patient, new knowledge of his or her drinking chain often clarifies for the first time the relationship between thoughts and feelings and drinking behavior, a discovery one Panel member calls "taking the mystery out of drunkenness." This method provides insight into individual problems, demonstrates the links between psychosocial and health problems and drinking, and provides the data for a rational treatment plan and an explicit individualized prevention strategy.

Breaking drinking behavior into the links of a drinking chain serves treatment in other ways, too. It suggests elements of the community service network that may be helpful in establishing an integrated case management plan to resolve antecedent conditions (e.g., housing, financial, medical problems) that necessitate involvement from the community beyond the treatment program.

Behavioral treatment can be used with older adults individually or in groups, with the group process particularly suited to older adults. Equipped with the knowledge of the individual's drinking or drug abuse behavior chain, the group leader begins to teach the client the skills necessary to cope with high-risk thoughts or feelings. The leader teaches the older person to initiate alternative behaviors to drinking, then reinforces such attempts. The leader may demonstrate through role-playing alternative ways to manage high-risk situations, permitting the client to select coping behaviors that he or she feels willing and able to acquire. The leader may also ask for feedback from the group and use that feedback to work gradually toward a workable behavioral response specific to the individual. The behaviors are rehearsed within the treatment program until a level of skill is acquired. The patient is then asked to try out the behaviors in the real world as "homework." For example, a client who has been practicing ways to overcome loneliness or social

isolation may receive a community-based assignment in which to carry out the suggested behaviors. The individual reports back to the group, then the therapist and group members provide feedback and reinforce the individual's attempt at self-management (whether the outcome was a success or not). This process continues until the individual develops coping skills and brings the antecedents for abuse under self-control or self-management. Typically, as patients learn to manage the conditions (thoughts, feelings, situations, cues, urges) that prompt alcohol abuse, abstinence can be maintained. Defining drinking behavior antecedents is also useful for determining when a client is ready for discharge. When the individual has acquired and can successfully use coping behaviors specific to his or her antecedents for drinking, the treatment team might begin to assist the person in gradually phasing out of the program. Discharge that takes place before the client has acquired specific coping behaviors is almost certain to result in relapse - probably very soon after discharge.

One older adult-specific treatment program that has used these cognitive-behavioral and self-management approaches is the Gerontology Alcohol Project (GAP) (*Dupree et al.*). The program assessed antecedents on a typical day of drinking for each person entering treatment. Group treatment involved skill acquisition in order to cope with problems such as anger and frustration, depression and grief, tension and anxiety, lack of social support, passivity, and an unstructured life. GAP staff were encouraged to teach skills at a slower pace than might be used with younger adults and to limit the amount of information taught per session by following written curriculum manuals. These teaching guides provided age-specific examples and maintained consistency in teaching. Confrontation was not permitted. This facilitated more open discussion between staff and clients, encouraging clients to report instances when they slipped. This information was used in the group to help both the person who slipped and other clients. Each slip was diagrammed in terms of that person's drinking behavior chain, with the antecedent conditions and consequences, in order to teach group members how to avoid or manage their own high-risk situations. The group engaged in exercises or rehearsals of the necessary actions and cognitions to prevent one drink (a slip) from becoming a full relapse. A 1-year follow up of clients completing GAP indicated a high rate of success. Seventy-five percent of clients maintained their drinking reduction goals and increased the size of their social support networks (*Dupree et al.*). Later studies comparing early and late-onset older problem drinkers showed great similarity between these two groups' antecedents to drinking and treatment outcomes (*Schonfeld and*

Dupree). Another study described a behavioral regimen that included psycho education, self-management skills training, and marital therapy. A follow up study of 16 male inpatients, ages 65 to 70, undertaken 2 to 4 years after discharge, indicated that half were abstaining, two had reduced their drinking, and the remaining patients' drinking was destructive (*Carstensen et al.*). These studies recommend (and the Panel concurs) that treatment focus on teaching skills necessary for rebuilding the social support network; self-management approaches for overcoming depression, grief, or loneliness; and general problem solving (*Schonfeld and Dupree*).

Alcoholics Anonymous and Other Self-Help Groups

Many treatment programs refer patients to Alcoholics Anonymous (AA) and other self-help groups as part of aftercare. Providers should warn older patients that these groups might seem confrontational and alienating. The referring program should tell patients exactly what to expect - that the group discussions may well include profanity and younger members' accounts of their antisocial behavior. To orient clients to these groups, the treatment program may ask that local AA groups provide an institutional meeting as a regular part of the treatment program. Other options are to help clients develop their own self-help groups or even to facilitate the development of independent AA groups for older adults in the area.

Individual Counseling or Short-Term Psychotherapy

Individual counseling is especially helpful to the older substance abuser in treatment's beginning stages, but the counselor often must overcome clients' worries about privacy. Subjects that many older adults are loath to discuss include their relationships to their spouses, family matters and interactions, sexual function, and economic worries. It is essential to assure the client that the sessions are confidential and to conduct the sessions in a comfortable, self-contained room where the client can be certain the conversation will not be overheard.

Older clients often respond best to counselors who behave in a nonthreatening, supportive manner and whose demeanor indicates that they will honor the confidentiality of the sessions. Clients frequently describe the successful relationship in familial terms: "It is like talking to my son," or, "It is as though she were my sister." Older clients value spontaneity in relationships with the counselor and other staff members; a counselor's

appropriate self-disclosure often enhances or facilitates a beneficial relationship with the patient.

Because receiving counseling may be a new experience for the client, the provider should explain the basics of counseling and clearly present the responsibilities of the counselor and the client. Summarizing at the beginning of each session helps to keep the session moving in the appropriate direction. Summarizing at the end of a session and providing tasks to be thought about or completed before the next session help reinforce any knowledge or insights gained and contribute to the older client's feeling that she is making progress.

In individual sessions, counselors can help clients prepare to participate in a therapy group, building their understanding of how the group works and what they are expected to do. Private sessions can also be used to clarify issues when the individual is confused or is too embarrassed to raise a question in the group. As the client becomes more comfortable in the group setting, the counselor may decide to taper the number of individual counseling sessions. Likewise, the client may prepare for discharge by reducing the frequency or length of sessions, secure in the knowledge that more time is available if needed.

9. A Practical Guide to Psychiatric Advance Directives

What are Psychiatric Advance Directives?

A psychiatric or mental health advance directive (PAD) is a legal tool that allows a person with mental illness to state their preferences for treatment in advance of a crisis. They can serve as a way to protect a person's autonomy and ability to self-direct care. They are similar to living wills and other medical advance planning documents used in palliative care.

> *During the darkest moments the PAD speaks for me by allowing me to be an active part of my treatment when I am not able to.*
> *-Aaron Willis*

PADs have been around for years, but they aren't often used in clinical settings. Many people who live with mental illness, their families, and the professionals who serve them, are unaware of the existence of PADs. Even with awareness of their availability, persons with mental illness may find the legal forms difficult to navigate and may not be able to access legal guidance

> *"The reason I worked so hard to get my own personal PAD in place was because I never know when the day may come that I will not be mentally stable enough to make decisions regarding my own psychiatric healthcare. Trusting my brother and sister-in-law, wholeheartedly, I know that with them on my PAD to make those decisions for me, I'll be taken care of. They know my wishes and are aware of the medications and procedures I am or am not willing to take or be a part of and I know they will advocate to the fullest for my wishes and my care."*

> *Laws on PADs vary by state. In general, a PAD has two parts: an advance instruction and a health care power of attorney. A person who wishes to develop a PAD can use one or both parts. The advance instruction can detail preferences for treatment, give consent for admission and consent for contact in advance. It can detail preferred medications and treatment modalities. It can also give instructions for tending to practical life matters, such as child care and contacting an employer. The health care power of attorney can be used for medical or psychiatric emergencies. It allows the person to appoint a trusted individual to serve as health care agent with decision*

on their completion. Clinicians may also be unsure of how best to incorporate PADs into clinical practice. And professionals who work in crisis settings and emergency psychiatric settings may be unfamiliar with the tools and reluctant to give up clinical authority for treatment decisions in busy crisis settings.

A PAD goes into effect when a person is found to lack decision-making capacity. A treating physician or psychologist makes the decision about capacity based on how the person presents at the time of examination. Some examples of periods when a person may lack capacity include acute psychosis, mania, catatonia, delirium, or unconsciousness. In a crisis situation, if a person has been deemed incapable, the PAD goes into effect and treating medical professionals can refer to the PAD to get a clear description of the person's preferences for treatment, who to contact in their support network, and how best to support the person in crisis. If there is a health care power of attorney in place, the designated health care agent can make decisions in the person's interest. PADs are only used temporarily, and only when the person is incapable of making or communicating treatment

decisions. Once the person regains decisional capacity, they can resume participating directly in decisions about care.

Any adult of sound mind can create a PAD. The witnessing process serves to attest to the person's sound mind and the voluntary aspect of PAD creation. Researchers found that part of the motivation for having a PAD comes from a desire to avoid coercive interventions. In one study, when respondents were asked about their past treatment experiences, 82 percent reported some kind of crisis event that involved health care agent can make decisions in the person's interest. PADs are only used temporarily, and only when the person is incapable of making or communicating treatment decisions. Once the person regains decisional capacity, they can resume participating directly in decisions about care.

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History

The history of PADs is related to medical advance directives for end of life planning. These original advance directives were born out of a Supreme Court decision in the Cruzan v. Director, Missouri Department of Health (*Cruzan v. Director, Missouri Department of Health, 497 U.S. 261*), which said that clear and convincing evidence of a patient's preferences were required for removal of life support. Nancy Cruzan was in a persistent vegetative state after a car accident. Her parents sought removal of a feeding tube, but the state would not allow them to make that decision given that their daughter was incompetent and they did not have clear evidence of her wishes regarding life support. The Supreme Court decided in favor of the Missouri Department of Health. The case spurred interest in the expansion of living wills and medical advance directives. Shortly after that decision, the Patient Self-Determination Act operationalized advance directives by requiring hospitals receiving federal assistance to ask patients if they had an

advance directive or would like one, to give them information about how to create one, and to honor them.

In the 1990's, PADs developed in parallel to medical advance directives and as a component of recovery-oriented care. PADS have been seen as a mechanism to facilitate engagement of persons in directing their own care at times of incapacity so that the crisis is overall less disruptive and disabling and so that the person can resume wellness as soon as possible. PADs differ from medical advance directives in several key respects – living wills or medical advance directives require thinking forward to a future state that a person has never experienced before, while the information in PADs is often based on past treatment experiences. A PAD can serve as a kind of self-prescription that binds the person to decisions made in advance. This aspect of the PAD should be clearly described to the person who is interested in creating one. Once a person has been deemed incapable, the PAD is not revocable until the person regains decisional capacity. In most states, the laws regarding PADs give broad deference to physicians to preserve their ability to make clinical judgments. For example, in North Carolina, if a person writes an advanced directive that does not align with community practice standards, the physician can make note of that in the record and can then provide treatment that is within professional accepted standard of care for that person's condition. PADS can also be overridden by involuntary treatment or other pressing emergencies. Even in these situations, they can still be referred to for information on who to contact and to learn about the person's preferences for care.

Resources on PADs and Crisis Planning

National Resource Center on Psychiatric Advance Directives
Established in 2005 with funding from the John D. and Catherine T. MacArthur Foundation, the National Resource Center on Psychiatric Advance Directives (NRC-PAD), is a partnership between patients, providers and organizations interested in PADs. The NRC-PAD, directed by Drs. Swartz and Swanson, has developed a web portal-based "community of interest" around PADs, disseminating educational resources, toolkits with step-by-step instructions on PAD completion, live and archived webcasts and links to all U.S. statutes on medical and psychiatric advance directives. NRC-PAD is a platform for national dissemination efforts for PADs-related research. NRC-PAD makes available information to assist state legislators,

policymakers, clinicians, consumers, and family members on matters related to PADs.

NAMI Resource Guide
NAMI developed a resource guide Navigating a Mental Health Crisis https://www.nami.org/About-NAMI/Publications-Reports/Guides/Navigating-a-mental-health-crisis/Navigating-a-mental-health-crisis.pdf?utm_source=website&utm_medium=cta&utm_campaign=crisisguide

Patient Self Determination Act of 1990
The Patient Self-Determination Act of 1990 https://www.congress.gov/bill/101st-congress/house-bill/4449 established the ability for patients to develop advance directives for their treatment at end of life. The law also applies more broadly to psychiatric and types of treatment

American Bar Association
Most hospitals, nursing homes, home health agencies, and HMO's are required to provide information on advance directives at the time of admission under a federal law called the **Patient Self-Determination Act (PSDA)** https://www.americanbar.org/groups/public
Act (PSDA) https://www.americanbar.org/groups/public_education/resources/law_issues_for_consumers/patient_self_determination_act.html

Crisis Navigation Project
A project to promote the use of psychiatric advance directives in North Carolina through providing education and training in facilitationhttp://www.crisisnavigationproject.org/

Mental Health America
Brief overview of the steps to creating a psychiatric advance directivehttp://www.mentalhealthamerica.net/creating-psychiatric-advance-directive

Virginia Advance Directives
An educational websitehttp://www.virginiaadvancedirectives.org/home.html on advance medical and mental health directives that is provided by Mental Health America of Virginia.

Video Resources

Crisis in Control, a film by Delaney Ruston

A 12-minute documentary on physician Delaney Ruston's efforts to encourage her father to create a [PADhttp://www.unlistedfilm.com/crisis.html](http://www.unlistedfilm.com/crisis.html), and stories from people who created their own and found them to be helpful tools for recovery. The video can be viewed on youtube. https://www.youtube.com/watch?v=-QUi2QGodI4

Jeffrey Swanson, PhD on NRC-PAD youtube channel:
A 5-minute educational video on psychiatric advance directives https://www.youtube.com/watch?v=eBSZ4ooRoZ8

NAMI North Carolina
A series of educational videos on PADs https://naminc.org/our-work-support/psychiatric-advance-directives/ of varying lengths, including a comparison with guardianship.

10. Additional Resources

Guidelines, Reports, Training Manuals, and On-Line Resources

✓ **Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults, American Geriatrics Society:** [http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations /2012](http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/2012) Potentially inappropriate medications (PIMs) continue to be prescribed and used as first-line treatment for the most vulnerable of older adults, despite evidence of poor outcomes from their use. The Beers Criteria were updated using a comprehensive, systematic review and grading of the evidence on drug-related problems and adverse drug events in older adults. Thoughtful application of the Criteria will allow for closer monitoring of drug use, application of real-time e-prescribing and interventions to decrease adverse drug events in older adults, and better patient outcomes.

✓ **Consensus Statement on Improving the Quality of Mental Health Care in U.S. Nursing Homes: Management of Depression and Behavioral Symptoms Associated with Dementia,** American Geriatrics Society & Association for Geriatric Psychiatry Journal of the American Geriatrics Society, 51(9), 1287–1298. This consensus statement, developed by an interdisciplinary panel of experts, focuses on the assessment and treatment of depression and dementia-related behavioral symptoms in nursing home residents.

✓ **Dementia in the Long-term Care Setting Clinical Practice Guideline, American Medical Directors Association** http://www.nhqualitycampaign.org/files/Excerpts_from_AMDA_Clinical_Guidelines.pdf. The purpose of this clinical practice guideline is to offer practitioners and care providers in LTC facilities a systematic approach to the recognition, assessment, treatment, and monitoring of patients with dementia, including impaired cognition and problematic behavior. It will provide a guide to appropriate management that maximizes function and quality of life, thereby minimizing the likelihood of complications and functional decline. The excerpts will focus on assessment, non-pharmacologic treatment and monitoring of a resident with dementia, including impaired cognition and problematic behavior.

✓ **Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change, American Psychological Association** http://www.apa.org/pi/aging/resources/dementia-guidelines.pdf The guidelines provide information on: the parameters of evaluation and evidence based practices; prevailing diagnostic nomenclature and specific diagnostic criteria; special issues surrounding informed consent in cognitively compromised populations; cultural perspectives and personal and societal biases related to dementia; standardized psychological and neuropsychological tests; and, the importance of providing constructive feedback, support, education, and interventions as part of the evaluation process.

✓ **Guidelines for Psychological Practice with Older Adults, American Psychological Association.** These guidelines are intended to provide practitioners with a frame of reference for engaging in clinical work with older adults, and basic information and further references in the areas of attitudes, general aspects of aging, clinical issues, assessment, intervention, consultation, professional issues, and continuing education and training relative to work with this group.

✓ **Blueprint for Change: Achieving Integrated Health Care for An Aging** Population, American Psychological Association, Presidential Task Force on Integrated Health Care for an Aging Population. http://www.apa.org/pi/aging/programs/integrated/integrated-healthcare-report.pdf. The intent of the Blueprint is to provide information on how

healthcare professionals, individuals and families can work together to ensure appropriate, effective, and integrated healthcare for the increasing number of older adults. As interdisciplinary health care teams often function differently according to the site, models for different settings, including long-term care settings are discussed.

✓ **Advancing Excellence in America's Nursing Homes**, Center for Medicare and Medicaid Services Multiple training programs/materials available for providers, clinicians, consumers and surveyors on the Advancing Excellence website and several association, university websites as well. http://www.nhqualitycampaign.org

✓ **Behavior Modification: Theory and Approaches, Center for Medicare and Medicaid Services** http://surveyortraining.cms.hhs.gov/pubs/ VideoInformation.aspx?cid=1087 Surveyor training by Leon Hyer, PhD, examines the role of behavior modification strategies that are commonly employed in the long-term care setting. The video emphasizes non-pharmacological interventions, although a general discussion of pharmacological alternatives and their effectiveness is included. The broadcast focuses on five major theories of behavior modification, with discussion and example scenarios for each.

✓ **STAR-VA: Manual for VA Community Living Center Mental Health Providers**, Karlin, B.E., Teri, L., McGee, J.S., Sutherland, E., Asghar-Ali, A, Crocker, S.M., et al. Washington, DC: Office of Mental Health Services, Department of Veterans Affairs (VA) Central Office. This manual describes the non-psychopharmacological program to reduce disruptive behavior in residents with dementia in long-term care settings.

✓ **Standards for Psychological Services in Long-Term Care Facilities** Lichtenberg, P. A., Smith, M., Frazer, D., Molinari, V., Rosowsky, E., Crose, R., Stillwell, N., et al. http://www.pltcweb.org/subject.php?target=standards Developed by the Psychologists in Long-term Care (PLTC), the standards address provider characteristics, method of referral, assessment practices, treatment, and ethical issues.

✓ **Non-Pharmacological Interventions for Behavioral Symptoms of Dementia**: A Systematic Review of the Evidence, O'Neil, M., Freeman, M., Christensen, V., Telerant, A., Addle man, A., & Kansagara, D. VA-ESP Project #05-225, Portland VA Medical Center, Portland, ORThis

report reviews systematically the evidence on non-pharmacological treatments for behavioral symptoms of dementia. It is estimated that behavioral symptoms occur in as many as 90 percent of people with Alzheimer's disease. Moreover, it is the behavioral symptoms that are most often cited by caregivers as the reason for the placement of individuals with dementia into residential care. Psychotropic medications are commonly used to treat the behavioral symptoms of dementia. There is little evidence, however, that such interventions are effective, and their potential side effects are frequent and often hazardous. It has been reported that the use of atypical and typical antipsychotic medication is associated with the increased risk of death. Because of the limited benefits and the potential harms associated with psychotropic medications, non-pharmacological interventions for the behavioral symptoms associated with dementia may be an attractive alternative to pharmacological treatment.

Journal Articles

Effective behavioral interventions for decreasing dementia-specific challenging behavior in nursing homes. Allen-Burge, R., Stevens, A. B., & Burgio, L.D. Journal of Geriatric Psychiatry, 14(3), 213.232. This paper provides a selective review of behavioral intervention research aimed at successfully decreasing dementia-related challenging behaviors in nursing homes. The authors include separate discussions of behavioral excesses (disruptive vocalization, wandering, physical and verbal aggression) and deficits (excess dependency, therapeutic activities, social interaction/ communication). Descriptions of interventions used to address each behavior problem are followed by methodological evaluations of the research. Discussions are augmented by inclusion of the authors' ongoing intervention research. The paper concludes with a description of a comprehensive program for teaching behavior management skills to nurse aides and a motivational system for maintaining the performance of these skills over the long-term.

Come talk with me: Improving communication between nursing assistants and nursing home residents during care routines Burgio, L. D., Allen-Burge R., Roth D. L., Bourgeois M. S., Dijkstra K., Gerstle J., et al., The Gerontologist, 41(4), 449-460. The effects of communication skills training and the use of memory books by certified nursing assistants (CNAs) on verbal interactions between CNAs (n = 64) and nursing home residents (n = 67) were examined during care routines. CNAs were taught to use communication skills and memory books during their interactions with

residents with moderate cognitive impairments and intact communication abilities. A staff motivational system was used to encourage performance and maintenance of these skills. Formal measures of treatment implementation were included. Results were compared with those for participants on no-treatment control units. Trained CNAs talked more, used positive statements more frequently, and tended to increase the number of specific instructions given to residents. Changes in staff behavior did not result in an increase in total time giving care to residents. Maintenance of CNA behavior change was found 2 months after research staff exited the facility. Although an increase was found in positive verbal interactions between CNAs and residents on intervention units, other changes in resident communication were absent. Nursing staff can be trained to improve and maintain communication skills during care without increasing the amount of time delivering care.

Teaching and maintaining behavior management skills in the nursing home Burgio, L. D., Stevens, A., Burgio, K. L., Roth, D. L., Paul, P., & Gerstle, J. The Gerontologist, 42(4), 487- 496. This study examined the efficacy of a comprehensive behavior management skills training program for improving certified nursing assistants' (CNA) skill performance in the nursing home, to assess the effectiveness of a staff motivational system for maintaining newly acquired behavior management skills for a 6-month period, and to evaluate any resulting effects on resident agitation. This study used a randomized clinical trial of 88 residents with behavior disturbances and 106 CNAs who cared for them in two urban nursing homes. After CNAs received 4 weeks of behavior management training, supervisory nursing staff implemented formal staff management (FSM), designed to maintain training effects over time. The supervisory staff used conventional staff management (CSM, usual supervisory routine) on control units. During the immediate post-training phase, both the FSM and CSM groups improved five out of seven communication skills and the ability to delay physical assistance during care routines. Although CNAs showed a reduction in the use of ineffective behavior management strategies, they did not increase their use of effective behavioral strategies. Follow-up assessments suggested that the FSM system was more effective than CSM for maintaining and even improving communication skills over time. Resident agitation was reduced during care interactions and maintained at follow-up. The behavior management skills training program improved CNAs' ability to interact with behaviorally disturbed nursing home residents and produced sustained reductions in agitation. The FSM system was more effective for maintaining communication skills 6 months after training.

Geropsychology Practice: One psychologist's experience in long-term care Burns, S. Psychological Services, 5(1), 73-84. The rapidly developing field of Clinical Geropsychology was acknowledged as a proficiency in 1998 by the American Psychological Association. This article presents one psychologist's perspective in an account of her 3 1/2 years of clinical experience working with an ethnically diverse, elderly cohort in a small, state-financed nursing home in Hawaii. Some practice setting challenges are presented, along with a portrayal of the benefits of interdisciplinary practice. The experiences described in this article are intended to provide support for the fundamental value and relevance of the Guidelines for Psychological Practice With Older Adults, and to encourage a more eclectic, adaptive, and inclusive practice model of therapy with the elderly that is evidence-based, person centered, and systems-oriented. Use of non-pharmacologic interventions among nursing home residents with dementia (*Camp, C.J., Cohen-Mansfield, J., & Capezuti, E.A., Psychiatric Services, 53(11), 1397-1401)*. The authors describe domains of non-pharmacologic interventions for residents with dementia who are receiving long-term care. Special emphasis is placed on interventions involving the domains of inappropriate behavior, restraint reduction, and cognition. Illustrations of the salubrious effects of these interventions are presented. For each domain, a review of the available information about non-pharmacologic interventions is provided, and areas in which additional information is needed are discussed. The authors conclude with a summary that emphasizes linkages and similarities among interventions across domains. The authors' major point is that effective non-pharmacologic interventions are available for a variety of behavioral problems that are commonly observed in long-term care settings.

Behavioral manifestations of pain in the demented elderly *Cipher, D.J., Clifford, P.A., Roper, K. Journal of American Medical Directors Association, 7(5), 355-365*. In long-term care settings, behavioral disturbances are exhibited more often by those residents with some level of cognitive impairment. The extent to which pain influences dysfunctional behaviors, and the extent to which pain manifests itself as dysfunctional behaviors, has not been empirically studied. The purpose of our study was to investigate the relationship between pain and behavioral disturbances among long-term care residents suffering from varying levels of dementia. A cross-sectional study of 277 long-term care residents aged 60 and older was conducted. Results suggest that pain influenced behavioral disturbances among those with severe dementia more often than those with moderate or mild dementia, and residents with chronic pain who have severe dementia exhibit significantly

more dysfunctional behaviors than those with earlier-stage dementia. These findings support the utility of comprehensive behavioral analysis involving clinical ratings of intensity, frequency, and duration of dysfunctional behaviors, with the assessment of the resident's level of dementia. The results imply that pain and other forms of physical suffering must be adequately treated in order to reduce behavioral disturbances and improve quality of life.

Efficacy of gero-psychological treatment in improving quality of life in long-term care: pain, depression, behavioral disturbances, ADLs, and health care utilization *Cipher, D.J., Clifford, P.A., Roper, K. Clinical Gerontologist, 30(3), 23-40.* Gero-psychological interventions have become a necessary component of quality long-term care (LTC) designed to address residents' co-morbidities involving emotional, functional, and behavioral difficulties. This two-part study was conducted to investigate the impact of Multimodal Cognitive- Behavioral Therapy (MCBT) for the treatment of pain, depression, behavioral dysfunction, functional disability, and health care utilization in a sample of cognitively impaired LTC residents who were suffering from persistent pain. In Study 1, 44 consecutive new patients received a comprehensive psychological evaluation, eight sessions of cognitive- behavioral therapy, and follow-up psychological evaluation over a five-week period. Analyses indicated that patients exhibited significant reductions in pain, activity interference due to pain, emotional distress due to pain, depression, and significant increases in most activities of daily living. They also exhibited significant reductions in the intensity, frequency, and duration of their behavioral disturbances, but not the number of behavioral disturbances. In Study 2, as a follow-up to Study 1, a retrospective chart review was conducted to compare the treatment group with a matched-control group on post treatment health care utilization. Comparisons between the two groups on Minimum Data Set (MDS) ratings indicated that the treatment group required significantly fewer physician visits and change orders than the control group. Implications of these collective findings are that geropsychological treatment is likely to improve certain aspects of residents' quality of life in LTC. The geriatric multidimensional pain and illness inventory: A new instrument assessing pain and illness in long-term care *Clifford, P.A., Cipher, D.J. Clinical Geropsychologist, 28 (3), 45-61.*

The Geriatric Multidimensional Pain and Illness Inventory (GMPI) was developed in order to assess the perceptual, functional, and emotional concomitants of pain and illness in long-term care. The GMPI was administered to 401 adults aged 60 and older residing in one of 16 long-term

care facilities. The GMPI items were analyzed for reliability, content validity, and convergent and discriminant validity. Factor analysis of the GMPI items revealed three subscales, level of pain severity, level of functional limitations associated with pain, and level of emotional distress associated with pain. The GMPI items were significantly correlated with items from the Geriatric Depression scale, the Neurobehavioral Cognitive Status Exam, and the Activities of Daily Living. The GMPI is evidenced to be a reliable and valid assessment tool for assessing pain of residents in long-term care facilities. State policies for the residency of offenders in long-term care facilities: Balancing right to care with safety *Cohen, D., Hayes, T., & Molinari, V. Journal of the American Medical Directors Association, 12(7), 481- 486.* The presence of residents in long-term care facilities who are registered sex offenders, other predatory offenders, parolees, or inmates transferred by correctional authorities is controversial and has raised concerns about how to care for this potentially dangerous population who may jeopardize the safety of others. Although the present offender population appears to be small, it is likely that demographic and economic pressures will increase its size. Since 2004, 14 states have passed legislation about placement of sex and other offenders in facilities and 5 have implemented non-law policies. Because legislation is relatively recent, it is not possible to evaluate best practices at this time. Research should be a priority to determine best policies and practices to balance the right to care with safety.

Can persons with dementia be engaged with stimuli? *Cohen-Mansfield, J., Marx, M. S., Dakheel-Ali, M., Regier, N.G. & Thein, K. American Journal of Geriatric Psychiatry, 18(4), 351-362.* The purpose of this study was to determine which stimuli are most engaging, most often refused by nursing home residents with dementia, and most appropriate for persons who are more difficult to engage with stimuli. Participants were 193 residents of seven Maryland nursing homes with a diagnosis of dementia. Stimulus engagement was assessed by the Observational Measure of Engagement. The most engaging stimuli were one-on-one socializing with a research assistant, a real baby, personalized stimuli based on the person's self-identity, a lifelike doll, a respite video, and envelopes to stamp. Refusal of stimuli was higher among those with higher levels of cognitive function and related to the stimulus' social appropriateness. Women showed more attention and had more positive attitudes for live social stimuli, simulated social stimuli, and artistic tasks than did men. Persons with comparatively higher levels of cognitive functioning were more likely to be engaged in manipulative and work tasks, whereas those with low levels of cognitive functioning spent

relatively more time responding to social stimuli. The most effective stimuli did not differ for those most likely to be engaged and those least likely to be engaged. Nursing homes should consider both having engagement stimuli readily available to residents with dementia, and implementing a socialization schedule so that residents receive one-on-one interaction. Understanding the relationship among type of stimulus, cognitive function, and acceptance, attention, and attitude toward the stimuli can enable caregivers to maximize the desired benefit for persons with dementia.

The impact of past and present preferences on stimulus engagement in nursing home residents with dementia *Cohen-Mansfield, J., Marx, M. S., Thein, K., & Dakheel-Ali, M. Aging and Mental Health, 14(1), 67-73.* Engagement with stimuli in 193 nursing home residents with dementia was examined. The expanded version of the self-identity questionnaire [Cohen-Mansfield, J., Golander, H. & Arheim, G.] was used to determine participants' past/present interests (as reported by relatives) in the following areas: art, music, babies, pets, reading, television, and office work. We utilized the observational measurement of engagement (Cohen-Mansfield, J., Dakheel-Ali, M., & Marx, M.S. Analysis revealed that residents with current interests in music, art, and pets were more engaged by stimuli that reflect these interests than residents without these interests. The findings demonstrate the utility of determining a person's preferences for stimuli in order to predict responsiveness. Lack of prediction for some stimuli may reflect differences between past preferences and activities that are feasible in the present.

Depression identification in the long-term care setting: The GDS vs. the MDS *Heiser, D. Clinical Geropsychologist. This study compared depression identification rates and validity of the currently mandated Minimum Data Set (MDS) and the Geriatric Depression Scale Short Form-15 item (GDS)* in a sample of nursing home residents. Results indicate the GDS is a better tool for identifying depression than the MDS. The GDS, MDS Section E1, QI, and OSCAR screened 35%, 23%, 3%, and 4% positive for depression, respectively. Mean sensitivity and specificity for SADS-RDC (gold standard) vs. GDS, MDS Section E1, OSCAR, and QI were .91, .79, .83, and .88, respectively. Chi-square analyses indicated the GDS was the only test, in relation to the SADS-RDC to identify depressed residents p = .001.

Depression in long-term care *Hyer, L., Carpenter, B., Bishman, D., &Wu, H. Clinical Psychology: Science and Practice, 12, 280-299. The assessment and treatment of depression in long-term care (LTC) settings* poses unique challenges to both clinicians and researchers. In this review we discuss the

variety of forms depression can take among LTC residents and the influence the LTC environment can play on the development and maintenance of depression. We describe instruments that can be used to assess depressive symptoms, along with their strengths and liabilities. Additionally, we summarize treatment approaches, with an emphasis on the relatively limited number of empirically informed interventions. Throughout, we describe modifications that may improve the accuracy of assessment and the effectiveness of psychological treatments. Depression, while common among LTC residents, appears amenable to psychological intervention, although the field is far from identifying empirically supported treatments in the LTC setting.

Group, individual, and staff therapy: An efficient and effective cognitive behavioral therapy in long-term care *Hyer, L., Yeager, C. A., Hilton, N., & Sacks, A. American Journal of Alzheimer's Disease and other Dementias, 23(6), 528-539.* Depression is a major problem in long-term care (LTC) as is the lack of related empirically supported psychological treatments. This small study addressed a variant of cognitive behavioral therapy, GIST (group, individual, and staff therapy), against treatment as usual (TAU) in long-term care. 25 residents with depression were randomized to GIST (n = 13) or TAU (n = 12). Outcome measures included geriatric depression scale-short form (GDS-S), life satisfaction index Z (LSI-Z), and subjective ratings of treatment satisfaction. The GIST group participated in 15 group sessions. TAU crossed over to GIST at the end of the treatment trial. There were significant differences between GIST and TAU in favor of GIST on the GDS-S and LSI-Z. The GIST group maintained improvements over another 14 sessions. After crossover to GIST, TAU members showed significant improvement from baseline. 8 Participants also reported high subjective ratings of treatment satisfaction. This trial demonstrated GIST to be more effective for depression in LTC than standard treatments.

STAR-Caregivers: A community-based approach for teaching family caregivers to use behavioral strategies to reduce affective disturbances in persons with dementia *Logsdon, R.G., McCurry, S.M., & Teri, L. Alzheimer's Care Quarterly, 6(2), 146-153.* The STAR-Caregivers program is a behavioral intervention to decrease depression and anxiety in individuals with Alzheimer's disease and their family caregivers. It consists of 8 weekly in-home sessions followed by 4 monthly telephone calls. Community-based mental health practitioners were trained to conduct the systematic and standardized STAR-Caregivers program, and deliver it to family members who were caring for a relative with dementia at home. This article describes

the STAR-Caregivers program and presents illustrative case studies to demonstrate that master's-level practitioners in a community setting can effectively deliver behavioral interventions.

Evidence-based psychological treatments for disruptive behaviors in individuals with dementia *Logsdon, R.G., McCurry, S.M., & Teri, L. Psychology and Aging, 22(1), 28-36.* In this article, the authors review the literature regarding evidence-based psychological treatments (EBTs) for behavioral disturbances in older adults with dementia, as proposed by the American Psychological Association's Committee on Science and Practice of the Society for Clinical Psychology. Fifty-seven randomized clinical trials were reviewed for inclusion on the basis of titles or abstract information. Forty-three were excluded either because they did not meet EBT methodological criteria or because they involved environmental or psycho-educational nursing interventions in which the psychological component could not be separately evaluated. Fourteen studies were considered for inclusion as EBTs; of these, 8 showed significant differences between treatment and control groups. Results of this review indicate that behavioral problem-solving therapies that identify and modify antecedents and consequences of problem behaviors and increase pleasant events and individualized interventions based on progressively lowered stress threshold models that include problem solving and environmental modification meet EBT criteria. Additional randomized clinical trials are needed to evaluate the generalizability and efficacy of these and other promising psychological interventions in a variety of settings with individuals who have a range of cognitive, functional, and physical strengths and limitations.

An evidence-based exercise and behavior management program for dementia care *Logsdon, R., & Teri, L. Generations; 34(1), 80-83. The Reducing Disability in Alzheimer's Disease (RDAD)* program is a systematic, evidence-based approach designed to improve mood and increase physical activity for community residing individuals with dementia. RDAD focuses on teaching caregivers behavioral and problem-solving strategies to implement a regular exercise program and decrease behavioral disturbances in their care recipients. Results of a randomized, controlled clinical trial indicate that the RDAD program is both feasible and beneficial for community-residing individuals with a range of cognitive abilities and impairments. This article discusses how RDAD may be adopted and applied in community based agencies and settings.

Use of Montessori-based activities for clients with dementia in adult day care: *Effects on engagement Judge, K.S., Camp, C. J., & Orsulic-Jeras, S.*

American Journal of Alzheimer's Disease and Other Dementias, 15(1), 42-46. Clients with dementia in an adult day care center were observed taking part in regular activities programming or Montessori-based activities developed for persons with dementia. During the nine-month study, clients in Montessori-based activities exhibited greater amounts of constructive engagement, defined as motor or verbal behavior exhibited in response to the activity in which the client was taking part, than clients in regular programming. Montessori-based activities also elicited less passive engagement, defined as listening and/or looking behavior exhibited in response to the activity the clients were participating in, than regular programming. Implications of these results and ways to implement Montessori-based programming in settings serving persons with dementia are discussed.

Effect of a DVD intervention on therapists' mental health practices with older adults *Lysack, S., Lichtenberg, P., & Schneider, B. The American Journal of Occupational Therapy, 65(3), 297- 305.* The effectiveness of an educational intervention in DVD format aimed at strengthening the mental health practices of occupational therapists working with older adults was tested. The DVD intervention was tested in a pretest– posttest design. Occupational therapists (n= 30) completed a brief knowledge and attitude questionnaire; a chart review (n =383) of therapists' (n= 20) patients at 3 months before and 3 months after DVD training was also conducted. Questionnaire data showed that the percentage of therapists with correct answers increased 20%–30% for 5 of the 11 knowledge items. Chart review data showed therapists spoke more often with their older patients about mood, depression, and cognitive impairment; screened more often for depression and cognitive impairment; and reported findings more often to the treatment team after training.

BE-ACTIV: A staff-assisted behavioral intervention for depression in nursing homes *Meeks, S., Looney, S.W., Van Haitsma, & Teri, L. The Gerontologist, 48 (1), 105-114.* This article describes a 10-week, behavioral, activities-based intervention for depression that can be implemented in nursing homes collaboratively with nursing home activities staff, and presents data related to its development, feasibility, and preliminary outcomes. BE-ACTIV, which stands for Behavioral Activities Intervention was developed in two pilot study phases: a treatment development phase and a feasibility–outcome phase with a small, randomized trial. The intervention was piloted with five depressed residents in a single nursing home in collaboration with the social services and activities staff. The second phase

randomized 20 residents from six nursing homes to receive either the intervention or treatment as usual. The intervention was well received by residents, family, and staff members. Experience with the intervention and input from staff members resulted in modifications to streamline the intervention and improve implementation. Results suggest that BE-ACTIV reduced institutional barriers to participation in pleasant activities, increased resident control over activity participation, increased overall activity participation, and improved depressive symptoms. Despite low power, statistical and graphical comparisons suggest superiority of the intervention over treatment as usual. Because depression among nursing home residents is prevalent, heterogeneous, and often treatment resistant, there is a need for effective, low cost interventions that are ecologically acceptable and efficient. BE-ACTIV is a promising intervention; it is brief, addresses institutional barriers, involves facility staff in treatment, and is acceptable to residents.

Improving the quality of long-term care *Molinari, V. Clinical Geropsychologist, 28 (3), 111-112. Improving the Quality of Long-term Care* is a follow-up on the IOM's original report documenting the changes that have occurred in the long-term care industry since OBRA took effect. Its examination of the quality of long-term Care is a follow-up on the IOM's original report documenting the changes that have occurred in the long-term care industry since OBRA took effect. Its examination of the quality of long-term care (LTC) provided by nursing homes and other LTC sites provides a broad over-arching framework for understanding the positives and negatives of current LTC practice and for planning future initiatives. It addresses the need for the provision of additional training for all nursing home staff including medical directors, nursing home administrators, nurses and nursing assistants. The emphasis on consumer choice and preferences is commendable. The IOM bluntly acknowledges that little change will occur without the federal and state governments' recognition that the labor-intensive nature of simple but effective interventions requires reforms in reimbursement procedures.

Special series of articles on professional psychology in long-term care *Molinari, V., P. & Hartman-Stein (Eds.). In Clinical Psychology: Science and Practice, 7 (3), 312-344.* With the overall aging of the population and the concomitant need for the provision of mental health care for older adults, professional psychology in long-term care has come of age. Psychologists are now increasingly practicing in such traditional long-term care settings as nursing homes and in less traditional ones such as rehabilitation units, day

centers, partial hospitalization programs, and hospices. The practice of psychology in long-term care is strongly influenced by public policy issues relating to Medicare, such as conditions of reimbursement, the rise of managed Medicare, and the continued disparity between payment for mental health and medical diagnoses. The articles in this special section on long-term care summarize the research on assessment and interventions for long-term care patients, outline the training opportunities available, and provide a decision-making framework for the common professional ethical/legal issues encountered in long-term care settings.

Serious mental illness in Florida nursing homes: Need for training *Molinari, V., Merritt, S., Mills, W., Chiriboga, D., Conboy, A., Hyer, K., & Becker, M. Gerontology and Geriatrics Education, 29, 66-83.* This study examined how the mental health needs of nursing home (NH) residents with serious mental illness (SMI) are addressed. Data were collected from three sources: interviews with 84 SMI stakeholders; surveys of 206 NH staff members; and focus groups at two psychiatry specialty NHs. Four common themes emerged: placement of older adults with SMI was a significant problem for discharge planners and NH admission coordinators; NH staff reported being uneasy with SMI residents and were concerned over aggressive behavior; staff in NHs with psychiatry specialty units appeared more comfortable serving SMI residents; and SMI training was a consistent recommendation of all SMI stakeholders and NH staff. Implications for training are discussed.

Mental health services in nursing homes: A survey of Florida nursing home administrative personnel *Molinari, V., Hedgecock, D., Branch, L. Brown, L., & Hyer, K. Aging & Mental Health, 13, 477-486.* Mental health problems are pervasive in nursing homes (NHs), but little is known regarding the delivery of mental health services in these settings. To fill this gap in knowledge, a survey of NH administrative personnel views on mental health services use was conducted. 146 surveys from NH administrative personnel were analyzed, reflecting 70% of the NHs that sent representatives to training conferences held at four Florida locations. Results showed substantial provision of mental health services (approximately half of the NHs have psychologists, psychiatrists and other MDs consulting on a weekly basis) and high satisfaction with services currently offered. Mental health services are typically provided by outside consultants who most frequently address behavior problems, anxiety/fears and depression. Sub-analyses of mental health service usage by types of NHs were largely non-significant. Almost half of the NHs reported the involuntary hospitalization

of at least one resident during the previous year. No barriers to mental health services were rated as serious, and no mental health services were viewed as very difficult to provide. Top perceived barriers to mental health services delivery were resident and family attitudes towards mental health services; administrator and staff attitudes were perceived to be less problematic. Specialty psychotherapeutic services were the most difficult to provide in NHs, with psychopharmacological interventions the least difficult to provide. In conclusion, administrators report a variety of mental health services provided by a diverse group of professionals in NHs, and are generally satisfied with the treatment provided.

Provision of psychopharmacological services in nursing homes Molinari, *V., Chiriboga, D., Branch, L., Cho, S., Turner, K., Guo, J., & Hyer, K. Journals of Gerontology: Psychological Sciences and Social Sciences, 65(1), 57-60.* We examined the psychopharmacological services provided within 3 months of nursing home (NH) admission to a whole population of newly admitted Florida NH residents 65 years and older (N = 947) for a 1-year period via secondary analyses of selected variables from Medicaid and the Online Survey and Certification and Reporting System. Within 3 months of admission, 12% received non-psychopharmacological mental health care. However, 71% of new residents received at least one psychoactive medication, and more than 15% were taking four or more 11 psychoactive medications. Most of those being treated with psychoactive medication had not received psychopharmacological treatment 6 months prior to admission (64%) and had not received a psychiatric diagnosis 6 months preceding admission (71%). Blacks were less likely to receive medications than non-Hispanic Whites. Results expand on past research by identifying an increase in the amount of psychoactive medications prescribed to NH residents, a lack of prior psychiatric treatment and diagnoses for those currently receiving psychoactive medications, only limited provision of non-psychopharmacological mental health care, and racial or ethnic differences in the use of medications by NHs.

Reasons for psychiatric prescription for new nursing home residents *Molinari, V., Chiriboga, D. A., Branch, L.G., Schinka, J., Schonfeld, L., Kos, L., Mills, W., Krok, J., & Hyer, K. Aging & Mental Health, 15(7), 904-912.* This article focuses on justification of psychoactive medication prescription for NH residents during their first three months post-admission. Data was extracted from 73 charts drawn from a convenience sample of individuals who were residents of seven nursing homes (NHs) for at least three months. Six focus groups with NH staff were conducted to explore rationales for

psychoactive medication usage. Eighty-nine percent of the residents who received psychoactive medications during the first three months of residence had a psychiatric diagnosis, and all residents who received psychoactive medications had a written physician's order. Mental status was monitored by staff, and psychoactive medications were titrated based on changes in mental status. One concern was that no Level II Pre-admission Screening and Annual Resident Review (PASRR) evaluations were completed during the admissions process. Further, while 73% had mental health diagnoses at admission, 85% of the NH residents were on a psychoactive medication three months after admission, and 19% were on four or more psychoactive medications. Although over half of the residents had notes in their charts regarding non-psychopharmacological strategies to address problem behaviors, their number was eclipsed by the number receiving psychopharmacological treatment. While the results suggest that NHs may be providing more mental health care than in the past, psychopharmacological treatment remains the dominant approach, perhaps because of limited mental health training of staff, and lack of diagnostic precision due to few trained geriatric mental health professionals. A critical review of the role of the PASRR process is suggested.

Commentary on the current status and the future of behavior therapy in long-term care settings *Molinari, V., & Edelstein, B. Behavior Therapy, 42(1), 59-65.* The mental health statistics for long-term care facilities are sobering. Nursing homes have been described as psychiatric institutions, but without the trained mental health personnel to provide appropriate psychiatric treatment. The strategies and behavioral techniques utilized in working with frail older adults in long-term care settings have become more sophisticated over the years. The evidence base for psychological treatment for older adults is expanding rapidly, and given the complexity of the problems encountered, geropsychology has been and will remain multimodal in its approaches to assessment and treatment.

Screening for mental disorders in residential aged care facilities *Pachana, N. A., Helmes, E., Byrne, G. J., Edelstein, B. A., Konnert, C. A., & Pot, A. M. International Psychogeriatrics, 22(7), 1107-20.* The International Psychogeriatric Association Task Force on Mental Health Services in Long-Term Care Facilities seeks to improve care of persons in residential aged care facilities (RACFs). As part of that effort the current authors have contributed an overview and discussion of the uses of brief screening instruments in RACFs. While no current guidelines on the use of screening instruments in nursing homes were found, relevant extant guidelines were

consulted. The literature on measurement development, testing standards, psychometric considerations and the nursing home environment were consulted. Cognitive, psychiatric, behavioral, functional and omnibus screening instruments are described at a category level, along with specifics about their use in a RACF environment. Issues surrounding the selection, administration, interpretation and uses of screening instruments in RACFs are discussed. Issues of international interest (such as translation of measures) or clinical concern (e.g. impact of severe cognitive decline on assessment) are addressed. Practical points surrounding who can administer, score and interpret such screens, as well as their psychometric and clinical strengths more broadly are articulated. In conclusion, guidelines for use of screening instruments in the RACF environment are offered, together with broad recommendations concerning the appropriate use of brief screening instruments in RACFs. Directions for future research and policy directions are outlined, with particular reference to the international context. Psychotherapy in Long-term Care: I. Practical Considerations and the Link to Policy and Advocacy Powers, D. Professional Psychology, Research and Practice, 39(3), 251-256. This article is the 1st of 2 examining 3 domains that are important to providing high-quality, evidence-based services to long-term care (LTC) residents: policy and advocacy, practical considerations, and outcome research. Older adults who reside in LTC facilities have a very high rate of mental health difficulties. Psychologists have been able to provide services to this population through Medicare since the late 1980s, resulting in an increase in psychologists who are working with LTC residents, either as part of their practice or on a full-time basis. The focus of this article is on practical considerations for therapists in LTC settings from both the published literature and personal observations (including an illustrative case example), the current policy environment, and the importance of advocacy on behalf of clients. Psychotherapy in Long-term Care: II.

Evidence-Based Psychological Treatments and Other Outcome Research *Powers, D. Professional Psychology, Research and Practice, 39(3), 257-263.* This article is the 2nd of 2 that together examine 3 domains important to providing high-quality, evidence-based services to long-term care (LTC) facility residents: policy and advocacy, practical considerations, and outcome research. Older adults who reside in LTC facilities have a very high rate of mental health difficulties. Psychologists have been able to provide services to this population through Medicare since the late 1980s, and empirical findings on treatment approaches are important in guiding psychotherapists to more helpful intervention. The focus of this article is

outcome research in LTC settings. This article emphasizes evidence-based psychological treatments (EBTs) but also examines other scientifically supported approaches and discusses the strengths and limitations of focusing on EBTs, as well as general issues in the relation between science and practice in the provision of psychotherapy in LTC settings.

Assessment and management of behavioral disturbances in Alzheimer's disease *Teri, L., & Logsdon, R.G. Comprehensive Therapy, 26(3), 169–175. nursing home patients with dementia.* This article provides an update and review of strategies for assessing and treating behavioral changes in patients with Alzheimer disease. It discusses the impact of behavioral disturbances, on patients, presents guidelines for identifying and monitoring behavioral changes, and presents behavioral treatment approaches.

STAR: A dementia-specific training program for staff in assisted living residences *Teri, L., Huda, P., Gibbons, L.E., Young, H., & van Leynseele, J. The Gerontologist, 45(5), 686-693.* This article describes, and provides data on, an innovative, comprehensive, dementia-specific training program designed to teach direct care staff in assisted living residences to improve care and reduce problems in residents with dementia. STAR, which stands for Staff Training in Assisted living Residences, provides two 4-hr workshops augmented by four individualized on-site consultations and three leadership sessions. Developed by means of an iterative process of implementation and revision, it was then evaluated in a small randomized controlled trial. A total of 114 staff and 120 residents in 15 residences participated. STAR was exceptionally well received. Training details are provided with a discussion of unique challenges inherent in implementation. Following training, STAR residents evidenced significantly reduced levels of affective and behavioral distress compared with control residents. Furthermore, STAR residents improved whereas control residents worsened.

Books Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists American Bar Association Commission on Law and Aging & American Psychological Association.

Handbook of Health and Behavior: Psychological Treatment Strategies for the Nursing Home Patient *Casciani, J. C. San Diego, CA: Concept Healthcare.* This Handbook represents an innovative response to the trend toward increased medical complexity in nursing home patients, and to the demand for greater behavioral health collaboration in their treatment plans. It is a portable reference guide for health care professionals who want to understand the recommended cognitive-behavioral approaches for the co-morbid psychological issues impacting medical conditions in nursing

facilities, including diabetes, respiratory disease, obesity and chronic pain, and diagnoses requiring rehabilitation, such as stroke and fractures. An array of assessment measures are discussed, and cognitive-behavioral treatment protocols are reviewed for twelve acute and chronic medical conditions. This Handbook will serve as an indispensable tool to help patients mentally manage their disabling medical conditions.

Handbook of Counseling and Psychotherapy with Older Adults *Duffy, M. New York, NY: John Wiley & Sons.* This book serves as a resource for mental health professionals who provide counseling and psychotherapy to older adults. The editor divides the book into two sections. Part I focuses on treatment modalities including the psychotherapy process, group approaches, family and systemic approaches, and social and community interventions. Part II provides interventions for a series of specific problems.

Handbook of Behavioral and Cognitive Therapies with Older Adults *Gallagher-Thompson, D., Steffen, A.M., & Thompson , L.W. (Eds.). New York: Springer.* Brings together expert scientist practitioners and the full spectrum of cognitive and behavioral interventions to promote age-appropriate best practice. The book enhances the professional's understanding of the learning and self regulating capacities of older adults. Its consistent and easy-access format features empirical reviews, recommended cognitive and behavioral interventions specific to the problem, instructive case studies, and salient diversity issues. In their choice of topics, the editors have assembled the Handbook to fit the unique challenges of both older individuals and the practitioners working with them. Topics covered include: common conditions, including depression, anxiety, insomnia, and pain syndromes, severe mental illnesses such as bipolar disorder, schizophrenia, dementia; grief and loss, family care giving, suicidality, underserved populations, including ethnically and culturally diverse individuals, emerging areas of mental illness management, and effects of Medicare on practice. This is important information for use by frontline mental health professionals and in graduate and advanced courses. Reflecting a rapidly developing field, this resource will open up new areas of research and inspire the next wave of treatments tailored to this rapidly expanding population.

Geropsychological Interventions in Long-Term Care Hyer, L. & Intrieri, R. C. New York, NY: Springer Publishing. Using Baltes' selection, optimization, and compensation model to conceptualize treatment in long-term care settings, this volume includes chapters on the context and trends of

long-term care practice, integration of medical and psychological care, identity issues of nursing home residents, interventions, and training.

Assessing and Treating Late-Life Depression: A Casebook and Resource Guide *Karel, M. J., Ogland-Hand, S., & Gatz, M. New York, NY: Basic Books.* This practice-oriented, research-based casebook draws on extensive clinical and academic data on late-life depression and its treatment as a resource for practitioners and researchers. With a rapidly aging population, depression among the elderly has become a critical issue for the mental health and medical communities. The authors provide an interdisciplinary framework for understanding and treating late-life depressive symptoms and elucidate the problems and principles of late-life depression with fourteen extended case studies. Explicating the range of syndromes and strategies for assessing and treating them, they conclude with a guide to medications, screening tools, innovative models, and supplementary resources.

Neurocognitive Disorders in Aging *Kempler, D.Thousand Oaks, CA: Sage Publications.* This is a comprehensive, well written introduction to common disorders that yield cognitive and behavioral problems in older adults. Both diagnosis and treatment are discussed.

Psychotherapy with Older Adults (3rd Ed.) *Knight, B. G. Thousand Oaks, CA: Sage Publications, Inc.* Provides the knowledge, technique, and skills required to be an effective therapist for older adults. Considers essentials of gerontology and the nature of therapy. Case examples are provided. Includes chapters on building rapport with the older client, grief work with older adults, and life review in psychotherapy with older adults.

The Guide to Psychological Practice in Geriatric Long-Term Care *Lichtenberg, P. A. New York, NY: Haworth Press Inc.* Part one provides an integrative model of psychological services in geriatric care. Part two focuses on the most relevant clinical issues, encouraging psychologists to use their theoretical background and clinical training to investigate new long-term care topics.

Caring for people with challenging behaviors: Essential Skills and Successful Strategies in Long-Term Care *Long, S. W. Baltimore, MD: Health Professions Press.* In this book, the term behavior problem refers to any behavior that causes emotional or physical harm. It can be harmful to either the person engaging in the behavior or to someone else. From this point of view, a resident's hostile behavior aimed at someone else is a behavior problem. If a resident's behavior hurts someone else unintentionally, it is still considered a behavior problem. In addition,

behaviors related to depression, anxiety, or fear can be problematic. This book details techniques for successfully addressing such behavior.

Whole Person Dementia Assessment *Mast, B. Baltimore, MD: Health Professions Press.* Although we can't currently offer a cure for Alzheimer s, we can provide better information and advice to people with the disease (and their caregivers) to help improve their ability to live and cope with this challenging disease. This groundbreaking book shows how to start making a difference during the initial evaluation and beyond. Treating every assessment as more than a simple diagnostic process, Whole Person Dementia Assessment sets the stage for more constructive interventions, better care, and a higher quality of life throughout the disease process by providing a richer understanding of the person and the way the disease is affecting him or her. Blending traditional clinical evaluation procedures with more person-centered approaches, Whole Person Dementia Assessment shows how to assess a person's cognitive deficits while also discovering and emphasizing remaining strengths and abilities. Best practice assessment tools are recommended and provided, including a comprehensive, whole-person interview form. Backed by solid research findings, Dr. Mast demonstrates that geriatricians, psychiatrists, psychologists, social workers, and long-term care providers who incorporate these methods into their assessment processes, will substantially improve their ability to develop rapport with the person and family members.

Treating Dementia in Context: A Step by Step Guide to Working with Individuals and Families *McCurry, S., & Drossel, C. Washington, DC: APA.* In this book, the authors present a clear and practical blueprint for psychologists, physicians, nurses, social workers, and other health care professionals who work with dementia patients and their families. Their evidence-based contextual model of dementia care lays out broad intervention strategies, and encourages readers to use their own creativity and inner resources to develop appropriate solutions for each unique situation and individual. The chapters present a rich variety of vignettes that illustrate common quality-of-life concerns in dementia patients, including medical co-morbidities, patient/caregiver relationships, caregiver burnout, and interactions with health 16 care professionals. Throughout, the authors combine a comprehensive knowledge of the literature with their own extensive clinical experience in advocating a compassionate and open-minded stance that respects the individuality, preferences, and dignity of dementia patients. Health care professionals at all levels of experience, from

outpatient to assisted living to residential care settings, will find Treating Dementia in Context an inspirational resource for clinical practice.

Professional Psychology in Long-Term Care: A Comprehensive Guide *Molinari, V. (Ed.). New York, NY: Hatherleigh Press.* Provides therapists, mental health professionals, professors, students, and laypersons with the tools and skills necessary to administer optimal long-term care to a growing elderly population. The editor divides the book into the following three parts: assessment, treatment, and professional issues. The first section includes articles on psychopathological, neurological, and medical assessment. The following treatment section contains papers on individual therapy in long-term care, behavioral interventions for patients with dementia, and basic psychopharmacology in a nursing home. The last portion deals with professional issues such as ethics, public policy, and clinical research in long-term care.

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Emerging Practices for Psychologists in Long-Term Care. *Norris, M., Molinari, V., & Ogland-Hand, S. (eds.). Binghamton, New York: Haworth Press Inc.* This special issue of The Clinical Gerontologist was turned into an edited volume on geropsychology practice in long-term mental health care.

Psychotherapy for Depression in Older Adults *Qualls, S.H., & Knight, B.G. [Wiley Series in Clinical Geropsychology]. Hoboken, N.J.: John Wiley & Sons.* This book contains chapters written by different authors on assessment and treatment of depression. There are specific chapters on empirically--supported treatments for depression in older adults including cognitive--behavioral therapy, interpersonal psychotherapy, and problem--solving therapy. The book also discusses the social/cultural context of

psychotherapy with older adults, issues in providing psychotherapy to depressed older adults in long- –term care settings, how to build and manage a geropsychology practice.

Caregiver Family Therapy: Empowering Families to Meet the Challenges of Aging *Qualls, S.H., & Williams, A.A. APA Books.* Caring for an older family member with physical or cognitive impairments is a difficult, strenuous process. Caregivers often struggle to balance their own needs with those of the care recipient. Their relationships with family, friends, coworkers, and even the care recipient can suffer as well. As a result, family members often seek professional help to guide them through the care giving process. This book presents Caregiver Family Therapy (CFT), a systems approach to treating families that care for an aging adult. CFT consists of three core stages: identifying the problem, structuring caregiver roles, and ensuring caregiver self-care. Transition stages bridge one core stage to the next, helping caregivers structure care for the older adult, examine the impact of care giving role structures, and consider broader effects of care giving. As new challenges arise, the stages are repeated and the CFT process begins anew. Full of rich clinical examples, this book will help therapists and other service providers meet the complex, diverse needs of care giving families.

Geropsychology and Long-Term Care: A Practitioner's Guide *Rosowsky, E., Casciani, J., & Arnold, M. New York, NY: Springer.* Among the growing population living in nursing homes and assisted-living communities, emotional and behavioral problems are frequently under-diagnosed and under-treated. Psychologists in Long-term Care (PLTC) has been instrumental in establishing standards for appropriate, respectful, and ethical care, and developing education and training resources for professionals. The contributors, all experts affiliated with PLTC, offer information that is up to-date, readily accessible, and eminently useful, whether the reader needs information on bedrock skills, multidisciplinary treatment, privacy issues, or the way facilities are run. The topics covered include common psychological disorders in long-term care, and their prevalence; federal policy issues affecting care delivery; and, the funding and referral processes in nursing homes. It also covers assessment tools commonly used with elders in 17 long-term care along with treatment plans and process, including the integration of psychiatric medicine into therapy. It later examines types of LTC providers, their training, and their roles in multidisciplinary care. Finally it discusses outcome measurement and Medicare documentation.

Personality Disorders and Older Adults: Diagnosis, Assessment, and Treatment. *Segal, D. L., Coolidge, F. L., & Rosowsky, R. Hoboken, NJ: John Wiley & Sons.* The older adult population is booming in the United State and across the globe. With this boom comes an increase in the number of older adults who experience psychological disorders. Current estimates suggest that about 20% of older persons are diagnosable with a mental disorder: Personality disorders are among the most poorly understood, challenging, and frustrating of these disorders among older adults. This book is designed to provide scholarly and scientifically-based guidance about the diagnosis, assessment, and treatment of personality disorders to health professionals, mental health professionals, and senior service professionals who encounter personality-disordered or "difficult" older adults.

Aging and Mental Health (2nd Ed.) *Segal, D. L., Qualls, S. H., & Smyer, M. A. Malden, MA: Wiley-Blackwell.* Offers a comprehensive review of models of mental health and their implications for treatment of older adults. Includes discussion of the development and implementation of evidence-–based treatment protocols; the increasing prevalence of cognitive impairment and an appreciation of its implications for a variety of functional behaviors; and a changing understanding of long–term care away from a focus on institutional care and toward a broader spectrum of services.

The Essential Dementia Care Handbook. *Stokes. G., & Goudie, F. (Eds.). Oxon, UK: Speechmark Publishing Ltd.* This very practical and informative book discusses the diagnosis of dementia and other problems associated with aging. The sections on assessment, functional analysis, and addressing challenging behaviors are particularly useful for long-term care settings.

Mental Disorders in Older Adults: Fundamentals of Assessment and Treatment (2nd Ed.) *Zarit, S. H., & Zarit, J. M. New York, NY: Guilford Press.* This book provides professionals and students with essential knowledge and skills for effective practice with older adults and their caregivers. Combining their expertise as a researcher and an experienced clinician, the authors offer a unique perspective on how to understand the challenges facing older adults and help them live more fulfilling, healthy, and independent lives. Illustrated with ample clinical material, the book reviews normal aging processes and presents a framework for assessment and treatment. Frequently encountered clinical problems are examined-- including dementias, mood and anxiety disorders, paranoid symptoms, and more--and specific applications of a variety of therapies are described. The authors also address the nuts and bolts of providing family support, consulting in institutional settings, and dealing with ethical issues

surrounding confidentiality, informed consent, and end-of-life decision making. Increased attention is given to different forms of dementia and how to distinguish among them. Coverage of psychopharmacology and combined treatments also has been expanded, with a focus on enhancing multidisciplinary collaboration.

Book Chapters

Long-term care institutions and maintenance of competence: A dialectic between compensation and overcompensation *Baltes, M. M., & Horgas, A. L., in Societal mechanisms for maintaining competence in old age: Societal impact on aging Willis, S. L., & Schaie, K. W. (Eds.). New York, NY:* Springer Publishing This chapter summarizes the authors' sequential observation and ecological intervention research on the role of social environment of institutions in fostering dependency and on interventions in the social environment in promoting independence.

Evidence-based treatments for behavioral disturbances in long-term care *Curyto, K. J., Trevino, K. M., Ogland-Hand, S., & Lichtenberg, P. in Making evidenced-based psychological treatments work with older adults F. Scogin & A. Shah (Eds.)(pp. 167-223).* Washington, DC: American Psychological Association. This chapter discusses evidence-based treatments for behavioral disturbances in long-term care. Extensive research on nonpharmacological interventions for disruptive behavior has been conducted. Three theoretical frameworks can be used to organize this research: the learning behavior model (LBM), the person–environment fit model, and the need-driven behavior model. The next section of this chapter discusses each model and its supporting evidence. In practice, these models overlap and often lead to similar interventions, as they all focus on how the environment can be changed (to change antecedents–consequences, to adjust to abilities and disabilities, or to meet needs respectively).

Psychotherapeutic interventions for older persons with dementing disorders *Duffy, M., in Strategies for therapy with the elderly Brody, C. New York, NY: Springer Publishing* This chapter encompasses three major areas of work with clients aged 60 years and older: Living in nursing homes, living in assisted living housing while participating in community-oriented activities for the aged, and living independently and being seen in private practice. It comprises a variety of approaches, ranging from eclectic small group formats for nursing home residents, group and individual counseling in assisted living settings, home care for the elderly, to psychoanalytic therapy techniques in private practice. Illustrative case examples used

throughout the book bring to life successful strategies and interventions. New areas of focus include: Treatment of stress and mental disorders, Alzheimer's disease, care giving issues at home, and expanded information on Medicare coverage issue.

Psychological assessment in geriatric settings *Edelstein, B., Martin, R. & Koven, L., in Handbook of Psychology: Volume 10 Graham, J.R., Naglieri, J.A., Weiner, I.B. (Eds.). New York, NY: John Wiley & Sons, Inc.* The principal goal of this chapter is to acquaint the reader with assessment issues that are relatively unique to older adults, with particular attention to factors that could influence the process or outcome of clinical assessment. The chapter begins with the discussion of two intra- and interpersonal variables-- bias in the form of ageism and cultural competence. Ignorance of the importance and influence of these variables can lead to corruption, contamination, and invalidation of the entire assessment enterprise. The authors then consider biological and medical issues that are more common among older adults that can play a significant role in the interplay between biological and environmental factors. Next, the chapter shifts to two conceptual issues, beginning with the assessment paradigms within which the clinician performs the assessment. The authors then address diagnostic issues and question the prudence of utilizing traditional diagnostic taxonomies with older adults. The complexities of carrying out clinical assessments are then addressed through discussions of multiple-method and multidimensional assessment. The authors follow this with a discussion of psychometric considerations for developing or selecting assessment instruments suitable for older adults.

Resources for Older Adults and Their Families

American Psychological Association (APA) Office on Aging www.apa.org/pi/aging APA

Family Caregivers Briefcase. State and National Resource Locators and Tools to Coordinate Caregiver Support http://www.apa.org/pi/about/publications/caregivers/resources/locators.aspx

Resources for Caregivers of Adults and Older Adults http://www.apa.org/pi/about/publications/caregivers/resources/adults-older.aspx19

APA Division 12-Section II - Society for Clinical Geropsychology
www.geropsych.org

APA Division 20 - Adult Development and Aging http://apadiv20.phhp.ufl.edu

Center for Medicare and Medicaid Services Partnership to Improve Dementia Care in Nursing Homes http://www.nhqualitycampaign.org/star_index.aspx?controls=dementia

Care Children of Aging Parents http://caps4caregivers.org/ Eldercare Locator http://www.eldercare.gov/

Leading Age http://www.leadingage.org/

National Care Planning Council http://www.longtermcarelink.net/

National Coalition on Mental Health and Aging www.ncmha.org

National Consumer Voice for Quality Long-Term Care http://www.theconsumervoice.org

Nursing Home Compare http://www.medicare.gov/NursingHomeCompare/search.aspx?bhcp=1

Psychologists in Long-term Care (PLTC) http://www.pltcweb.org/

Generations United www.gu.org
Generations United (GU) focuses solely on promoting intergenerational strategies, programs, and policies. GU serves as a resource for educating policymakers and the public about the economic, social, and personal imperatives of intergenerational cooperation.

National Council on Aging (NCOA) www.ncoa.org
Founded in 1950, NCOA is the nation's first association of organizations and

professionals dedicated to promoting the dignity, self-determination, well being, and contributions of older persons.

Senior Corps www.seniorcorps.org

Senior Corps is a network of programs that tap the experience, skills, and talents of older citizens to meet community challenges with Foster Grandparents, Senior Companions, and RSVP (Retired and Senior Volunteer Program). Senior Corps, part of the USA Freedom Corps, is administered by the Corporation for National and Community Service, the federal agency that also oversees AmeriCorps and Learn and Serve America.

AARP www.aarp.org
AARP conducts and publishes a wide range of studies on aging. Most of it is available at their Online Research Center at http://research.aarp.org/

Administration on Aging www.aoa.gov
This government agency, which is part of the Department of Health and Human Services, provides a great deal of information about the economic and health status of older Americans.

U.S. Census Bureau www.census.gov
Provides a wide range of statistics on demographics as well as economics of Americans of all ages.

Federal Interagency Forum on Aging-Related Statistics http://www.agingstats.gov

This site provides access to a comprehensive report, Older Americans: *Key Indicators of Well-Being*.

Civic Ventures www.civicventures.org
This non-profit organization, which is the parent of Experience Corps, conducts research and publishes studies on topics such as attitudes toward retirement and volunteering and civic engagement among older Americans. Most of this research is available online.

Independent Sector www.independentsector.org
An excellent source of information about the involvement of Americans as volunteers. Independent Sector has just published a new report, Experience at Work: Volunteering and Giving Among Americans 50 and Over.

International Longevity Center www.ilcusa.org
An independent research organization that conducts and publishes research on many subjects related to the extension of the life span and its social and economic impacts.

The Eldercare Locator (1-800-677-1116) can direct you to your Area Agency on Aging. They will give you information on local long-term care resources and programs. Visit their website at http://www.aoa.dhhs.gov.

The Nursing Home Information Service at the National Council of Senior Citizens has information on community services and offers a free guide on how to select a nursing home. Visit their website at http://www.ncscinc.org.

The Health Care Financing Administration publishes the "Guide to Choosing a Nursing Home" and the annual "Guide to Health Insurance for People with Medicare." The nursing home guide includes a detailed checklist. Call 1-800-638-6833. Visit their website at http://www.hcfa.gov.

Each state Office of the Long-Term Care Ombudsman visits nursing homes on a regular basis and handles complaints. Find your ombudsman by calling the National Association of State Units on Aging at 202-898-2578. The association has publications about long-term care and can provide a list of facilities.

Other Sources of Information Include:

The American Association of Homes and Services for the Aging
901 E Street, N.W., Suite 500
Washington, D.C. 20004-2011
202-783-2242
http://www.aahsa.org

The Assisted Living Federation of America
Suite 400, 10300 Eaton Place
Fairfax, VA 22030
703-691-8100
http://www.alfa.org

The American Health Care Association

1201 L Street, N.W.
Washington D.C. 20005
202-842-4444

The National Citizens' Coalition for Nursing Home Reform's publication list is available from Suite 202, 1424 16th Street, N.W., Washington, D.C. 20036-2211; call 202-332-2275.

For more information about health and aging, contact:

National Institute on Aging
Information Center
P.O. Box 8057
Gaithersburg, MD
20898-8057
1-800-222-2225
1-800-222-4225 (TTY)
http://www.nih.gov/nia

Alzheimer's Disease Education and Referral (ADEAR) Center
P.O. Box 8250
Silver Spring, MD 20907-8250
1-800-438-4380
http://www.alzheimers.org

11. References

AARP, Staying Ahead of the Curve.

Albright, Ada, Bonnie Brandl, Julie Rozwadowski, and Mary K. Wall. *Building a Coalition to Address Domestic Abuse in Later Life.* National Clearinghouse on Abuse in Later Life and AARP Foundation National Legal Training Project, www.ncall.us/docs/BuildingCoalitionParticipantRev.pdf

Alexopoulos, G. S., Raue, P., Areán, P. Problem-solving therapy versus supportive therapy in geriatric major depression with executive dysfunction. American Journal of Geriatric Psychiatry, 11(1), 46–52.

Alexopoulos, G. S., Raue, P. J., Kanellopoulos, D., et al. Problem solving therapy for the depression-executive dysfunction syndrome of late life. International Journal of Geriatric Psychiatry, 23(8), 782–788.

Areán, P., Julian, L., & Raue, P. PST for older adults with depression and executive dysfunction. Unpublished manuscript.

Areán, P., & Dwyer, E. V. Problem solving therapy for homebound elderly. Unpublished manuscript.

"The Art of Active Listening,"*Aging I&R Tip Sheet No. 5*. Washington, DC: National Association of State Units on Aging. Schechter, Susan. *Guidelines for Mental Health Practitioners in Domestic Violence Cases*. Washington, DC

Bath, P.A., Differences between older men and woman in the Self-Rated Health/ Mortality Relationship. The Gerontologist, 43 387-94

Brandl, Bonnie, Carmel Dyer, Candice Heisler, Joanne Otto, Lori Stiegel, and Randy Thomas. *Elder Abuse: A Multidisciplinary Approach.* New York: Springer, in press.

Carreira, K., Miller, M. D., Frank, E., et al., A controlled evaluation of monthly maintenance interpersonal psychotherapy in late-life depression with varying levels of cognitive function. International Journal of Geriatric Psychiatry. DOI: 10.1002/gps.2031.

Charles, S.T., Reynolds, C.A., & Gatz, M., Age-related differences and change in positive and negative affect over 23 years. *Journal of Personality and Social Psychology*, 80, 136-151.

Clingan-Fisher, Deanna. "Elder Abuse and the Legal Services Connection,"

Colello, Girvan, Mulvey, & Talaga, 2012; Genworth Financial, 2012; MetLife Mature Market Institute, 2012.

Commission on Long-Term Care, 2013; Reinhard, Kassner, Houser, & Mollica, 2011.

Craik & T.A. Salthouse (Eds.), *The Handbook of Aging and Cognition* (pp. 293-357). Mahwah, NJ: Erlbaum

Federal Interagency Forum on Aging-Related Statistics 2012 http://www.agingstats.gov, Older Americans 2012: Key Indicators of Well-Being.

Floyd, M., Scogin, F., McKendree-Smith, N. L., et al. (2004). Cognitive therapy for depression: a comparison of individual psychotherapy and bibliotherapy for depressed older adults. Behavior Modification, 28 (2), 297–318.

Haringsma, R., Engels, G. I., Cuijpers, P., et al., Effectiveness of the Coping With Depression (CWD) course for older adults provided by the community-based mental health care system in the Netherlands: a randomized controlled field trial. International Psychogeriatrics, 18(2), 307–325.

Interpersonal psychotherapy for elderly patients in primary care. American Journal of Geriatric Psychiatry, 14(9), 777–786.van Schaik, D. J., van Marwijk, H. W., Beekman, A. T., et al., Interpersonal psychotherapy (IPT) for late-life depression in general practice

The Journals of Gerontology, Series A. Biological Sciences and Medical Sciences, 51(4), M172–178.van Schaik, A., van Marwijk, H., Ader, H., et al..

Kaye, H. S., Harrington, C., & LaPlante, M. P. (2010). Long-term care: who gets it, who provides it, who pays, and how much? Health Affairs, 29(1), 11-21

Laidlaw, K., Davidson, K., Toner, H., et al, A randomized controlled trial of cognitive behavior therapy vs. treatment as usual in the treatment of mild to moderate late life depression. International Journal of Geriatric Psychiatry, 23(8), 843–850.

Masoro E.J. & Austad S.N. (eds.): Handbook of the Biology of Aging, Sixth Edition. Academic Press. San Diego, CA, USA, 2006. ISBN 0-12-088387-2

National Aging Information and Referral Support Center. "The Art of Active Listening,"*Aging I&R Tip Sheet No. 1*. Washington, DC: National Association of State Units on Aging.

National Coalition Against Domestic Violence, *Older Americans 2012: Key Indicators of Well- Being*

Saltzman LE, Fanslow JL, McMahon PM, Shelley GA. Intimate partner violence surveillance: uniform definitions and recommended data elements,

version 1.0. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Saltman, R.B.; Dubois, H.F.W.; Chawla, M., "The Impact Of Aging On Long-term Care In Europe And Some Potential Policy Responses

Saltzman LE, Fanslow JL, McMahon PM, Shelley GA. Intimate partner violence surveillance: uniform definitions and recommended data elements, version 1.0. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Strawbridge, W.J., Wallhagen, M.I. & Cohen, R.D., Successful aging and well-being: Self-rated compared with Rowe and Kahn. The Gerontologist.

Stone, R.I., & Benson, W.F., Financing and organizing health and long term care services. In Prohaska, T. R., Anderson, L. A., & Binstock, R. H. (Eds.). (2012). Public Health for an Aging Society. Boston. Johns Hopkins University Press.

U.S. Department of Health and Human Services, *AHCPR Research on Long-term Care*

Valdiserri, R. O., HIV/AIDS stigma: an impediment to public health. American Journal of Public Health, 92, 341–342.

World Health Organization, *Aging and Life Course*

WHO, Second Generation Surveillance for HIV/AIDS

World Health Organization, EXECUTIVE BOARD EB124/6
124th Session 20, Provisional agenda item 4.3.

WHO/UNAIDS/UNICEF (2011) 'Global HIV/AIDS Response: Epidemic update and health sector progress towards Universal Access 2011' - 2011
Zacks, R.T., Hasher, L., & Li, K.Z.H. Human memory. In F.I.M.

SMI References

1. Vespa, J., Armstrong,D.M.,&Medina,L. (2018). Demographic turning points for the United States: population projections for2020 to 2060.*Current Population Reports*,Report Number P25-1144, U.S. Census Bureau.

2. Administration on Aging, Administration for Community Living.(2018). *2017profile of older Americans.*Washington, DC: U.S.Department of Health and Human Services.

3.U.S. Census Bureau.(2017). The nation's older population isstill growing: thenation's population isbecoming more diverse.Release Number: CB17-100.

4. Hudson C.G. (2012). Declines in mental illness over the adult years: an enduring finding or methodological artifact *AgingMentalHealth*,*16*(6),735-52.5.IOM (Institute of Medicine).(2012).*The mental health and substance use workforce for older adults: inwhose hands?* Washington, DC: The National Academies Press.

5.American Psychological Association.(2014). Guidelines for psychological practice with older adults.*American Psychologist,69*(1),34-65.

6.Lehmann S.W., Brooks W.B., Popeo D., Wilkins K.M.,&Blazek M.C. (2017).Development of geriatric mental health learningobjectives for medical students: A response to the institute of medicine 2012 report.*The American Journal of GeriatricPsychiatry*,*25*(10),1041-7.

7.Liebel D.V.,&Powers B.A.(2015).Home health care nurse perceptions of geriatric depression and disability caremanagement.*The Gerontologist,55*(3),448-61.

8.IOM (Institute of Medicine).(2008).*Retooling for an aging America: Building the health care workforce.*Washington, DC: TheNational Academies Press.

9.The 21st Century Cures Act.(2015)H.R. 34, 114th Congress.

10. Vespa, J. (2018). *The graying of America: More older adults thankids by 2035*. U.S. Census Bureau. www.census.gov/library/stories/2018/03/graying-america.html March 2018

11. U.S. Census Bureau. (2018). *Older people projected to outnumber children for first time in U.S. history*. Release Number: CB18-41.

12. U.S. Census Bureau. (2017). *The 2017 national populations projections* from https://www.census.gov/programs-surveys/popproj.html

13. Center for Behavioral Health Statistics and Quality (CBHSQ). (2017a). *2016 national survey on drug use and health: Detailedtables*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

14. As defined in the U.S. Federal Register, Vol. 58, No. 96; May 20, 1993.16. SAMHSA and AOA. (2013). *Issue brief 8: Integration of behavioral health and physical health care*. RetrievedonMay 1, 2018from https://www.ncoa.org/wp-content/uploads/Issue-Brief-8-Integration.pdf

15. American Association of Suicidology. (2017). *Suicide data 2015*. Retrieved onMay 1, 2018 fromhttp://www.suicidology.org/Portals/14/docs/Resources/FactSheets/2015/2015datapgsv1.pdf?ver=2017-01-02-220151-870.

About the Course Presenter:
Course Presenter Nicole Hiltibran, MA, LMFT, is a graduate from Pepperdine University, where she earned her Masters Degree in Clinical Psychology with an emphasis in Marriage and Family Counseling, and is a Licensed Psychotherapist. Nicole has 25 years of experience serving adults, children, couples and families both in the public sector and private practice. Nicole has written state licensing exams for the California State Board of Behavioral Sciences for 10 years as well as offering continuing education courses to licensed mental health and social work professionals including LMFT's, LCSW's, LPCCs, RN's, and PhD's.